

MAMA ALWAYS SAID:
THE TRANSMISSION OF HEALTH CARE BELIEFS AMONG
THREE GENERATIONS OF RURAL BLACK WOMEN

BY

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In the field of health care, effective information transfer is a major problem at both the community and individual level. Unfortunately, the importance of cultural beliefs and practices in the health care encounter are often disregarded or minimized. This research examines the transmission of health care information, attitudes, and practices among three generations of women in a representative rural black community in the American South. Rather than looking at the community as a single entity, this study examines the continuities and discontinuities in health care beliefs and practices among three generations of family members in four age cohorts. Hypertension, a prevalent health problem in the black community, was chosen as the focus of inquiry. Four interrelated hypotheses regarding community health beliefs and practices were tested using data gathered through participant observation, focused interviews, standardized tests, and a secondary source review.

Research findings indicate that older women in the community are still perceived as important sources of general health care information. However, their influence has been attenuated through contact with the health care system and through health information provided by the mass media and school based health education. The four age cohorts reported differential degrees of reliance on the various sources of health information: younger women relied more heavily on the mass media and health care professionals for health information than did older women.

However, data regarding health care practices related specifically to hypertension indicate that in actuality there are few differences among the age groups. Although in general the responses across generations were similar, there was a trend towards more biomedically congruent beliefs and practices among younger respondents.

Recommendations are made for incorporating these findings into both clinical practice and community education to provide more culturally relevant health education and medical care at both the individual and group level. The generalization of these conclusions to other communities and other health problems is indicated.

CHAPTER I INTRODUCTION

The Place of the Study

Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses and counselors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, traveling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on experience from neighbor to neighbor and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. Medicine is part of our heritage as women, our history, our birthright.
(Ehrenreich and English, 1973, p. 3)

Authors of anthropological, sociological, historical and popular literature have discussed the importance of women as the chief repository of medical folk wisdom and the primary transmitter of this knowledge to succeeding generations. Studies done in the American South (Hill, 1976; Dougherty, 1976, 1978; Hill and Mathews, 1981; Mongeau et al., 1961; Murphree, 1968, 1976; Puckett, 1926; Flint, 1979; Watson, 1984) indicate that in both black and white rural populations, women hold

. . . the great mass of folk medicine in their hands . . .
the women are the great practitioners, the folk doctors.
The old granny with her "yarbs an' intmints" does much to keep alive these folk cures. (Puckett, 1926, p. 385)

Snow (1974), Harwood (1981) and Jackson (1981) indicate that this role is found among blacks in urban areas as well. This finding is not surprising given the shared cultural heritage of blacks in the New World. Most urban blacks have migrated within a generation or two from the rural areas, and many retain close ties with rural kin.

However, there has been little attention accorded this significant role of women in the medical literature or in clinical practice. In fact, despite efforts by applied medical anthropologists to integrate a sociocultural awareness into the medical encounter, there has been little regard among health care practitioners for the cultural belief systems of their patients. In addition, health care professionals make certain assumptions about health care information flow that ignore the existing health care beliefs and practices that patients bring to the clinical encounter. Most health and patient education efforts are predicated on the notion that health information is transmitted unidirectionally from the knowledgeable health care practitioner to the unknowing patient. It is presumed that the patient wants to know and then adopt the scientific "truths" that the practitioner presents. There is little evidence to suggest an appreciation of the patients' powerful belief system--its genesis or influence in the clinical situation.

Purpose and Approach of This Study

This research examines the influence of black women as healers and health care resources in a small rural community in the American South. Rather than view the community as a single cultural entity, this study focuses on the continuities and discontinuities that exist as health

beliefs, values and practices are transmitted from one generation of women to another. Hypertension was chosen as the focus of inquiry based on its prevalence among the black population and its classification as a chronic condition. (There is some evidence to suggest that common and chronic conditions are more often treated within the popular folk domain while acute conditions are dealt with in the biomedical arena (Hill and Mathews, 1981). Through qualitative and quantitative research methodology, this study elucidates the sources of health information and the continuities and discontinuities that exist as health beliefs, values and practices vis a vis hypertension are transmitted from one generation to another in this representative rural black community.

Four interrelated hypotheses were formulated based on a review of social science literature, clinical nursing experience and anecdotal evidence. First, it is hypothesized that health care attitudes, beliefs and behaviors are orally passed from one generation to another by female relatives and other significant female members of the community. However, this influence is thought to be attenuated by exposure to other sources of health care knowledge, i.e., the mass media and contact with the bio-medical system. Thus, it is hypothesized secondly that there will be less reliance on the female based oral tradition as a source of health care knowledge in succeeding generations as a result of greater exposure to and reliance on other sources of health care information, i.e., radio, TV, magazines, newspapers, movies, books, schools and contact with the bio-medical system.

An associated hypothesis to be tested addresses the degree to which an individual feels she has control over her own health. This health belief which can be measured by the Health Locus of Control, a standardized testing instrument, is likely to be influenced by messages provided by mass media and health care professionals. Therefore, it is hypothesized thirdly that health care beliefs will reveal a decreasing locus of control in succeeding generations: that is, that younger members of the community will believe that they have more control over their health than their mothers and grandmothers believe they have over theirs.

A final clinically relevant hypothesis specifically concerns itself with the transmission of knowledge about the detection, treatment, and prevention of hypertension. The three preceding hypotheses are to be tested using hypertension as the clinical focus of the inquiry. It is hypothesized that members of the study population with hypertension will have a greater knowledge base regarding this disorder than those who do not have the condition. This hypothesis is predicated on the assumption that those who have been diagnosed as hypertensive will be more motivated to learn about illness and health care in general as well as have a need to learn more about their particular condition. Furthermore, one might assume that hypertensives have greater exposure to the health care resources related to their condition than do those who are not hypertensive.

In summary, these four hypotheses comprise the major thrust of this research effort. The generalizability of the study findings to other rural black communities in the South and possibly to other minority populations, as well as to patients with a variety of health

conditions, will hopefully aid practitioners in delivering more culturally relevant health care and assist health educators in designing more effective instructional interventions. Thus, the clinical application of the cultural realities provides the primary purpose for this research endeavor.

Background of the Study

A review of the literature indicates that black women as repositories of health care information derives from a long tradition of both informal and formal healing roles. A historical overview (Postell, 1970; Savitt, 1978; Robinson, 1979; Herskovits, 1941; Gutman, 1976; Harrison, 1976) indicates that the African slaves brought many of their traditional health care beliefs, values and practices to the New World. For instance, in America, herbs similar to those in Africa continued to be used for healing purposes while new herbal remedies learned from Native Americans and healing concepts from Europeans became incorporated into the Afro-American healing practices. However, Savitt (1978) maintains that the American cultural beliefs took precedence in the blacks' method of healing. Maintenance of these beliefs was expressed by one former slave who said, "all these doctoring things come clear from Africy, and dey allus worked for mammy and for me too" (quoted in Robinson, 1979, p. 89).

Black women, thus, passed on their healing practices to their families and communities. Royster (1983) indicates that often these women were the only ones knowledgeable about herbal remedies in their communities, so they became the main source of health care. Savitt (1978, p. 184) indicates that "they [black women] legally assisted

whites and blacks in delivering children, letting blood, pulling teeth, administering medicines and nursing the sick." In addition to their role as nurse, midwife and herbalist, black women functioned as conjurers and rootworkers. Using African tribal magic, violence, persuasion and considerable psychology, these conjure doctors cured a variety of illnesses. Although many of these traditional healing practices were viewed as dangerous by the slave owners, they were retained "clandestinely as part of religious observances" (Harrison, 1976, p. 559) by the slaves themselves. Thus, the intimations of healing and religious practices that will be discussed later in this review have a historical tradition in which black women play a key role.

Postslavery, medical care was not available to blacks due to racial discrimination, geographic inaccessibility and prohibitive financial costs. Home remedies provided by family members or other knowledgeable members of the community remained the primary form of health care. Thus, black women continued to be informal health agents in their communities.

More formally, black women began to practice medicine as physicians around 1900 (Royster, 1983). They continued to function as midwives, a role which eventually was sanctioned, indeed controlled, by the Public Health Departments of many southern states (Mongeau et al., 1961; Dougherty, 1978b) until recently.

Transmission of the Healing Tradition

Robinson (1979, p. 19) states that

. . . prior to the late 20th century Africans did not put into writing their beliefs or rituals. Their beliefs and rituals were transferred orally from one generation to another among members in the community and within individual family units.

It is only recently that black women writers such as Hurston, Walker and Morrison have begun to incorporate "the traditional Black female activities of rootworking, herbal medicine, conjure and midwifery into the fabric of their stories" (Smith, 1976, p. 164). Nevertheless, heavy reliance on the oral transmission of health care beliefs still exists among rural blacks today (Hill, 1976; Snow, 1977a; Taylor, 1976).

It is typically within the context of the family that adult members transmit the basic values and patterns of social behavior and other cultural knowledge to succeeding generations. The structure of the black family is an extended one--joining many multi-generational members of the kin network together for mutual aid and support (Gutman, 1975; Kunkel and Kennard, 1971; Martin and Martin, 1978; Dougherty, 1976; Shimkin and Demitri, 1971; Stack, 1974; Frazier, 1939; Ladner, 1971; Robert Hill, 1972; Reubin Hill, 1970). Thus, the socialization of children involves a variety of adult kin including parents, grandparents, aunts, uncles, adult cousins and siblings. Para-kinship ties described by Lewis (1975) in which kin-like relationships exist among nonrelated members of the community testify to the importance of

friends and neighbors as well as family members in the socialization process.

Though Hill (1972), Lewis (1975), Ladner (1971) and others have emphasized the flexibility and adaptability of sex roles within the black family, the primary responsibility for childrearing appears to be the purview of females (Stack, 1974; Dougherty, 1976; Staples, 1978; Martin and Martin, 1978; Mays, 1979). Some social scientists (Frazier, 1966; Moynihan, 1965) have blamed the widespread disorganization and pathology with which they characterize the black family on this imbalance in the female-male role model contribution to family living. This view which derives from an implicit nuclear family perspective has been challenged most recently by Billingsley (1968), Ladner (1971), Robert Hill (1972) and Stack (1974). These investigations, to the contrary, have emphasized the strength and resiliency of the black extended family.

On the whole, the research demonstrates that strong kinship bonds, religious orientation, adaptability of family roles, high values of individualism paired with strong interpersonal connectedness and strong achievement orientation are strengths of the black family. It is thought that these adaptive mechanisms, reportedly derived from the African cultural heritage, "facilitate the ability of the family to meet the needs of its members and demands made upon it by systems outside the family unit" (Nobles and Nobles, 1976, p. 7) and "have enabled the majority of Blacks to survive against seemingly insurmountable odds in a hostile environment" (Baer, 1981, p. 163).

These characteristics of the black family have particular significance for the health domain. In light of extended kin reliance for

support and aid, members of the black community are inclined to consult family members for health advice as a first step in dealing with illness. This lay consultation system has been described for the general population by Friedson (1970), McKinlay (1973), Kleinman (1978) and others.

Indeed, the whole process of seeking help involves a network of potential consultants, from the intimate, informal confines of the nuclear family through successively more select, distant authoritative laymen, until the professional is reached. (Friedson, 1970, p. 377)

In the black community, however, this lay consultation system is strengthened by the historical tradition of self-help and folk healing practices combined with tightly knit familial support networks.

Within the lay referral system, it is generally recognized that older women have traditionally served as the primary health agents in black communities in the South (Dougherty, 1976; Hill and Mathews, 1981). As such, they influence the utilization of the mainstream medical system as well as transmit health care beliefs, values and practices to other members of the family and community. Kleinman et al. (1978) have indicated that 70-90% of all health care takes place in the popular domain. Salloway and Dillion (1973) observed that there is less likelihood of utilization of professional health sources when family networks are relied on than when friend and coworker networks are consulted. Therefore, the influence of these black women as healers is considerable.

Religico-Medical System

The strong religious orientation of the black community has led to an inextricable blending of the religious and health domains (Snow, 1974, 1977b, 1978; Hill, 1973, 1976; Haskins, 1978; Straight, 1983; Smith, 1976; Doughtery, 1976; Scott, 1974; Weidman, 1978). This phenomenon is, of course, not unique to blacks. However, the particular religico-medical system comprised African traits, Voodoo elements, fundamentalist Christianity tenets and modern scientific beliefs is distinctive of blacks, especially those raised in the rural South.

Snow (1974, p. 8) summarizes the basic themes in this system:

1. The world is a hostile and dangerous place;
2. The individual is liable to attack from external sources; and
3. The individual is helpless and has no internal resources to combat such attack but must depend on outside aid.

Most health problems are attributable to disturbed social relationships, disharmony with nature, or divine punishment. Appropriate interventions are determined by the perceived causality of the illness. Accordingly, certain practitioners are utilized for disturbed social relations (e.g., minister, rootworker) while others are enlisted for help with disorders caused by nature imbalances (e.g., family members, physician) or divine punishment (e.g., minister, self-prayer). Although this folk medical system has been described in some detail by Snow (1974, 1978), Hill and Mathews (1981) and Haskins (1978), among others, the maintenance of these religico-medical beliefs across generations has not been explored. Some investigations have suggested

that the younger generation of blacks today may adhere less strongly to these beliefs than their forbears (Martin and Martin, 1978).

To summarize thus far, partly because of familial ties and community resources, and the blending of religious and health domain, and partly due to the inaccessibility of reasonably priced, culturally appropriate, community based health care services, rural blacks still participate in a dual system of health care. Folk medical practices exist side by side with mainstream medical care in this population as well as with rural whites (Murphree, 1976), urban blacks (Snow, 1977a) and in other ethnic groups as diverse as Mexican Americans (Bauwens, 1977), Native Americans (Adair, 1970) and Italian Americans (Ragucci, 1972).

Thus, this dual system of health care is not unique to minority populations so much in kind as in degree. Many groups rely on religious healing, self-diagnosis, and over-the-counter medications. However, rural blacks appear to rely more heavily on folk medicine for some conditions than for others. Data gathered by Hill and Mathews (1981) among blacks in North Carolina suggest that traditional or folk medicine is more frequently utilized for chronic health problems, and modern medicine more often employed for acute health problems.

Hypertension: A Chronic Health Condition with Compliance Problems

Hypertension, a chronic health problem prevalent in the black population, has been widely reported in the medical literature. Many of these articles explore the issue of patient noncompliance, exemplified by patients who (1) take medications irregularly or wrongly,

- (2) fail to alter life threatening or disease promoting behaviors and
- (3) fail to keep medical appointments at all or on time.

Caldwell et al. (1983) found that noncompliance was greater for patients who were nonwhite, less educated, from lower occupational and lower income levels and with shorter duration of disease. Various approaches have been suggested to ameliorate this situation: individual patient education (Webb, 1980), public health education through the use of mass media (Alcalay, 1983), mobilization of patient support systems (Caplan, 1979), psychosocial counseling (Webb, 1980) and increasing technical skills of home monitoring (Brody, 1980).

Few studies have focused on the patients belief system or have considered the role of sociocultural factors in the compliance problem. A review of 35 medical journal articles and manuals determined that only seven (20%) mentioned the importance of eliciting the patients' attitudes and beliefs in developing an efficacious treatment plan. On the contrary, many of those surveyed blamed the patient for treatment failures. A manual on hypertension control for nurses and other health professionals explains noncompliance in the following manner:

In terms of a patient who is interacting without satisfactory results, we first must assess the individual personality traits and their influence and implication for compliance. Is the patient hostile, aggressive, anxious, paranoid or hypochondriac? To determine the presence and level of patient resistance, hostility and opposition (overt and covert) the clinician can assess appointment attendance and punctuality. [Lateness can reflect hostility.] (Kochan and Daniels, 1978, p. 125)

Among 50 different suggestions for facilitating compliance in this otherwise excellent resource manual, there was no mention of

determining the influence of the patients belief system or other sociocultural factors.

A review of 21 patient education brochures on hypertension showed a similar disregard for the cultural beliefs and practices of the targeted population (see Appendix A for a complete list). Only one booklet acknowledged the importance of sociocultural factors in prevention or treatment of high blood pressure. Much more prevalent was the admonishment to follow the physicians orders, "Most of the time treatment failure is due to patient failure to follow the doctor's instructions" (USV Laboratories, 1980, p. 2). "The biggest obstacle to treatment is the patient's attitude . . . those who have the condition don't cooperate fully with their doctors. Be sure to do what he says" (Merck et al., 1982, p. 6). This sentiment is expressed implicitly or, more often, explicitly in 16 of the 21 brochures: the other five emphasized a physician-patient partnership.

The tacit assumption underpinning these patient education materials as well as most health education efforts today is that the patient is an empty vessel into which "scientific truths" can be poured. Without consideration for the patient's cultural belief system, this modus operandi is ineffective, and often, counterproductive.

In summary, a review of the relevant medical and social science literature supports the need for research focusing on the cultural belief systems of hypertensive patients. This dissertation research explicates the sources of health information and continuities and discontinuities that exist as health beliefs, values and practices vis a vis hypertension are transmitted from one generation to another in a rural black community in the American South. Women as the primary

health agents in the black community will be the focus of the inquiry. The purpose of this research endeavor is to demonstrate the relevance of cultural behavior to clinical management. The generalizability of the research findings to other rural black communities in the South and to patients with other chronic illness will aid practitioners who are working with a variety of populations deliver more culturally relevant health care and improve the patient-physician partnership.

CHAPTER II RESEARCH DESIGN AND METHODOLOGY

Choice of Overall Research Design

The research was conducted over a two and one half year period in Macedonia-Grove, a fictitious name given to a small rural community in North Central Florida. This community was selected for a variety of reasons. It is representative of other small rural communities in the Southeastern United States with regard to its demographic composition, socioeconomic status, the degree of isolation with regard to mainstream America, and the availability of community services. Furthermore, the community was accessible to the researcher since she had established ongoing relationships with many of the local residents in her role as nursing coordinator of a small health clinic located in Macedonia.

The research focused on blacks in this community because they constitute a geographically stable population across time and thus served as a more pure cultural group. Furthermore, health care professionals readily admit a particularly limited understanding of the cultural belief systems of this population. This lack of understanding often leads to frustration and inefficacy in clinical encounters. Therefore, it was hoped that research findings from this study would have clinical application and lead to more culturally appropriate health care and education.

Hypertension was chosen as a focus for inquiry, for a variety of reasons relating to prevalence, chronicity, and clinical relevance. It is a major health problem for blacks both nationally and locally. The American Heart Association (1979) indicated that 32% of black females in the United States have high blood pressure. The Division of Health and Rehabilitative Services (DHRS) for the State of Florida estimated that there was a prevalence rate of 35 hypertensives per 100 non-white females--yielding a total of 3,231 non-white female hypertensives in the research county. Since the 1980 U.S. Census Bureau reports indicate that there are less than 3% other non-white females in the research county one may surmise that most of the non-white females referred to above are black.

A 1977 medical anthropology survey of the research community (Albert et al.) reported that 41.7% of the patients interviewed had been treated for high blood pressure in the preceding year. Reviewing the files of the community health clinic, 39% of the patients seen during a 4 month period (selected at random) were treated for hypertension. Thus, this condition appears prevalent in the research community.

Furthermore, since chronic conditions, e.g., hypertension, are most often treated in the popular or folk domain rather than through the biomedical system, it seems reasonable to infer that the influence of orally transmitted beliefs, attitudes and practices will be most resilient and readily ascertained in this domain. Hypertension is commonly cited in the medical literature as a condition in which there are considerable patient compliance problems. Thus, it was decided to focus on this chronic condition that is prevalent in the black

community in order to shed light on a phenomenon which has clinical importance.

Since women are commonly held to be responsible for the health care of their family and socializers of succeeding generations, this study looked at women rather than men as the transmitters of health care beliefs. However, health care attitudes, beliefs and practices are not static across time. Ragucci (1972) points out that most comparative studies that deal with ethnic differences in perceiving and responding to illness disregard or minimize the differences which may exist between and within generations. Ragucci suggests that "valid generalizations about cultural differences and persistence and change in health beliefs and associated practices require adequate sampling of at least three generations" (1972, p. 164). This study considers the continuities and discontinuities that exist as health beliefs and behaviors are passed from one generation to another. Following Ragucci's suggestion, this research sampled three generations.

Recruitment of Subjects

Because of the research design, sampling was neither random nor static. Criteria for inclusion in the study sample changed across time. During the early stages of the fieldwork process, the sample was defined as all black adults who resided in the research community. As the research progressed (see the Chapter III for detailed stages of the fieldwork process), the sample became more narrowly defined to include only the female members of this black community. Initially, informants were recruited from groups in which the researcher participated, i.e., older women's quilting group, exercise class, women's health group.

This then was an opportunity sample. As the researcher became more involved in the community, she was referred to new interviewees through others in the community--especially through the key informants--thus forming a snowball sample.

As the study became more formalized and structured, the sampling became more purposive. In order to examine the transmission of health care beliefs and practices across three generations, subjects were identified based on the following criteria: lifelong residence in the research community, membership in a three generation kin or para-kin group, ability to comprehend the interview questions, and capacity to withstand the interview process.

Generational Groupings

Three generational groups were identified: parental (P), daughter (D) and grand-daughter (G). The parental group (P) included all women 50 years of age or older who have daughters and grand-daughters (or others who functioned in that role) still dwelling in the research community. Two women who had lived away from the community for 45 and 52 years, respectively, but who had returned to spend their elderly years there were excluded from the sample on the basis that residence in an urban area for 45 or more years might have differentially affected their health care beliefs. An additional four women were disqualified because they were unable to complete the interview due to illness or senility.

In summary, the "parental" generation (P) consisted of 23 women aged 54-85 years who had been identified as having been a primary caretaker for at least two generations of women in Macedonia-Grove.

Not all of those they cared for were biological daughters or granddaughters but they had all functioned in that capacity (i.e., been cared for and/or lived with a member of the parental generation).

These women spanned two age cohorts (36-59 years; 60+ years).

The "daughter" generation (D) consisted of women who had been raised by the women identified above. In one family two daughters were included because there was some question in the researcher's mind about the representativeness of one subject. These 24 women spanned three age cohorts (21-35 years, 36-59 years and 60+ years).

The "granddaughter" generation (G) was comprised of women who had been raised by the generation labelled "daughter." They also had frequent contact with the women in the parental generation (i.e., their grandmothers). These women spanned two age cohorts (13-20 years, 21-35 years). Because some of the women were quite young, two granddaughters were included from three of the families giving a total N of 26.

The total generation group then numbered 73. Of that group, 23 were in the parental group, 24 in the daughter group, and 26 in the granddaughter group. These 73 women represented 23 family or para-kin groups.

Age Groupings

The problems which definition of "generation" presented, i.e., a 50 year old woman could be a "mother" or "daughter"; a 24 year old woman could be a "daughter" or a "granddaughter" necessitated adding the age cohort groupings to control for differences based on age related variables (Table 2-1). Age cohorts were defined as teenagers

Table 2-1. Membership of generational groupings in age cohorts

Age cohorts	Generational groupings			Total N
	Parental "P" N	Daughter "D" N	Granddaughter "G" N	
60+ years	20	1		21
36-59 years	3	18		21
21-35 years		5	13	18
13-20 years			13	13
TOTAL	23	24	26	73

(13-20 years old), young adults (21-35 years), middle adults (36-59 years) and older adults (60+ years) modified from the groupings outlined by Health Services Analysis, Inc., for the Georgia State Department of Health (1981).

In order to make statistically valid comparisons by age cohorts as well as by familial groups, an additional 23 subjects were randomly selected by age groups from a list of community residents provided by several key informants. This yielded a total of 96 women ranging in age from 13-85 years. There were 24 subjects in each of the four age cohorts (Table 2-2) and Table 2-3 shows the mean age of each cohort.

In summary, subjects were recruited by "family" groups or by age cohorts. This sampling allowed for analysis of the continuities and discontinuities of health care beliefs among three generations of women. Since the generational groups were not congruent with age groups, an additional group of subjects was recruited in order to control for peer group influence. This study sample is representative of the community as a whole even though sampling was purposive rather than random.

As was noted above, very few women were excluded from the sample based on the selection criteria. The study sample represented 88% of the three generational families and 44% of the total black females age 13 years or older in the research community. Because of the age distribution in the community, the research sample of 96 was differentially representative of the total population of black women in the community: 70% of the total number of older women, 60+ years; 32% of the total number of middle aged women, 36-59 years; 30% of the total

Table 2-2. Membership of total sample in age cohorts

Age cohort	From family groups N	Additional subjects recruited N	Total subjects N
60+ years	21	3	24
36-59 years	21	3	24
21-35 years	18	6	24
13-20 years	13	11	24
TOTAL	73	23	96

Table 2-3. Mean age of each cohort

Cohort	Age range (years)	Mean age (years)
Old	60+	72.6
Middle	36-59	48.0
Young	21-35	28.1
Teen	13-20	16.7

number of young adults, 21-35 years and 76% of the total teen group, 13-20 years.

Construction and Implementation of a Focused Interview Guide

The preparation and use of a structured or focused interview guide is simply a formalization of basic interviewing techniques (Pelto, 1970) which provides an explicit documentation of the ethnographer's learning during informal fieldwork (Agar, 1980). Thus, a structured interview guide was constructed during the third stage of the fieldwork process (see Chapter III for a detailed description of the three stages of fieldwork) in order to provide quantifiable data for hypotheses testing. The focused interview guide (Appendix B) was designed to elicit accurate responses falling within a series of specified informational categories: demographic (16 questions Qn = 16), internal versus external health locus of control (Qn = 15), stated sources of health information (Qn = 12), and specific knowledge regarding the definition (Qn = 8), causes (Qn = 24), symptoms (Qn = 13), control (Qn = 17), consequences (Qn = 12), and prevention (Qn = 15) of hypertension.

The content for the inclusion of particular questions was derived from clinical practice, data gathered through participant observation and information culled from relevant social science and popular literature. For example, there were no choices listed under the section, "causes of hypertension," that had not been offered by one of the above stated sources.

The health locus of control scale was included because it is a standardized instrument that measures the degree to which an individual

believes he or she has control over matters of health and illness.

Coreil and Marshall (1982) administered this test to populations that are similar to the research population (i.e., poor whites living in rural Appalachia and poor blacks living in rural Haiti). The use of a standardized instrument allows for cross cultural comparisons and adds to the reliability of the research.

The format for the questions was patterned after Pelto's (1970) recommendation that effective interview schedules should contain a mixture of both open ended and fixed alternative or closed questions. The focused interview guide constructed for this study contained open ended questions followed by forced choices within each content section.

Professional Review of Interview Guide

The focused interview guide went through six drafts before it was finalized. To achieve intrinsic validity, a panel of three medical anthropologists, a physician, a statistician, and a research evaluator reviewed various drafts of the guide. Reviewers made suggestions concerning the rewording of some questions to provide clarity. Two reviewers suggested a couple of additional questions based on their clinical experience with the study population.

Patient Review Panel: A Pilot Study

A pilot study to explore the feasibility of the research design was conducted at a health clinic in University Town. This clinic draws a patient group from several outlying rural areas that are similar to the research community with regard to local resources, socioeconomic level, and demographic composition. Five patients who met the

following criteria--black, female, aged 13 years or older, rural domicile, and educational achievement ranging from 5th through 12th grade--were administered the fourth draft of the focused interview guide. Three of the five interviewees were hypertensive. There were a couple of translations of health terms into the common vernacular, i.e., stress = "worryation"; loss of sexual desire = "lose one's nature" that were incorporated into the interview guide. With these few exceptions, the pilot test indicated that the focused interview guide was socioculturally valid, contained wording that was clear and appropriate and that it would elicit the required information for hypothesis testing.

The fifth draft of the interview guide was reviewed by three women from the research community who were not part of the study sample. There were no additional suggestions made during this review cycle so the fifth draft was the actual draft administered to the study sample of 96 women. Some problems present during coding created the need for a sixth and final draft. Although it does not differ in content from the fifth draft, the final draft is in a more usable form for future research endeavors.

In summary, the focused interview guide was designed to elicit valid and reliable data regarding the transmission of health care beliefs and practices among three generations of rural black women. The forced choice and open ended questions on the interview guide are designed to elicit information regarding the transmission of general health beliefs as well as those specific to hypertension. The quantifiable data yielded by the structural interview supplements information gathered by other methodologies. The next section includes

a description of and justification for the choice of methodology in this research endeavor.

Choice of Methodology

Several of the major contributors to anthropological methodology (Pelto, 1970; Agar, 1980; Spradley, 1980) as well as sociologists McCall and Simmons (1969) and Glaser and Strauss (1967) advocate examining cultural behavior from a variety of different approaches. The use of both qualitative and quantitative data minimizes the constraints of each method when employed alone and greatly adds to the reliability and validity of the findings. Pelto argues that both the insider's definition and categorization of behavior, often referred to as the "emic" point of view, and the outsider's definitions of significant actions or cultural categories, often referred to as the "etic" point of view, are important for a complete picture of the phenomenon under investigation. Therefore, this study used multiple research methodologies to collect data on the transmission of health care beliefs among three generations of women in the research community. These included both qualitative and quantitative approaches.

There is disagreement in the literature whether or not it is necessary to enter the field with a theoretical model explicitly stated. Agar (1980, p. 172), for example, believes that "a precise theoretical and operational definition of the variables and a clear statement of the hypothesized covariation before the research begins," severely limit the information one gets. He prefers the formulation of "an idea to check out" (p. 171).

To recapitulate, the ethnographer enters the field with a broad definition of the research problem about which she/he has formulated some "ideas to check out." As more data are collected, the research problem becomes more narrowly focused and more clearly defined. Subsequently, the hypotheses or "ideas to be checked out" become more precise and informed. Theory, then, is derived from the data rather than vice versa. Pelto (1970), however, would argue that all research is structured in terms of some sort of theoretical constructs. He describes the three levels of theory: (1) a very general meta theory; (2) an implicit, often unconscious personal theory; and (3) explicit theory. He advocates formulating a hypothesis which he defines as "a tentative theory or supposition provisionally adopted to explain certain facts and to guide in the investigation of others" (Pelto, 1980, p. 45).

Working Hypotheses

The tentative hypotheses which guided my investigation were:

1. Health care attitudes, beliefs and behaviors are orally passed from one generation to another by female relatives and other significant female members of the community.
2. There will be less reliance on this female based oral tradition as a source of health care knowledge in succeeding generations as a result of greater exposure to and reliance on other sources of health care information, i.e., radio, TV, magazines, newspapers, movies, books, schools, and contact with the medical system.
3. Health care beliefs will reveal a decreasing external locus of control in succeeding generations.
4. Hypertensives will have a greater knowledge base regarding this disease than those who do not have the condition.

The following is a description of the methodologies employed in this study to move from a more generalized metatheoretical to a more explicit theoretical level.

Data Generating Methods

Pelto (1970) states that examining cultural behavior with a variety of different approaches greatly enhances the credibility of research results. A shifting back and forth between qualitative and quantitative research methodologies is suggested by a number of methodologists (Agar, 1980; Pelto, 1970; McCall and Simmons, 1969). The data generating methods employed in this research include respondent and informant interviewing, structured and unstructured observation, and examination of secondary source materials.

The fieldwork process, which is described in detail in Chapter III, proceeded in three distinct stages. The first two stages were characterized by standard ethnographic research methods: participant observation, informant interviews and an examination of a variety of documents and other secondary source material.

Demographic data were obtained in part through an examination of the 1980 U.S. Census materials. This information is essential not only for descriptive purposes but as documentation of the research community as representative of other small rural black communities in the American South. Data regarding family structure and residency patterns in the research community were gathered through genealogical inquiries of key informants and mapping of community residences. This information yielded valuable information regarding kin groups which was essential for adequate and representative sampling purposes.

A 1977 Needs Assessment of the research community (Albert et al.) provided data concerning health problems as perceived by community residents as well as those identified by health care providers at a local voluntary health clinic. The nurse researcher was able to corroborate information regarding diagnosis, health practices and compliance with prescribed regimes through access to patient charts at this health clinic. A content analysis of fiction by key black women writers (Hurston 1969a, 1969b, 1983; Walker, 1971, 1973a, 1973b, 1976, 1979b, 1982; Angelou, 1971, 1973, 1977; Morrison, 1973; Shange, 1977, 1978, 1982; Bambara, 1972, 1977; Naylor, 1983) provided data regarding the black woman's experience in the rural South which was helpful in placing data from the study in a larger cultural context.

Likewise, the researcher's attendance at conferences or events outside the community which focused on the experiences of black women provided contextual background against which the data from this study could be examined. Analyses of hymns sung by a local gospel group revealed important data regarding beliefs about the role of religion in health care beliefs in the research community as well as in other black communities in the South. Thus, an examination of secondary sources not only yielded important data regarding the community under study but also served as a vehicle for assessing the representativeness of the community.

Methods used for gathering primary data were participant observation and informant and respondent interviewing. Key informants were identified based on the following criteria identified by Pelto (1970) and Agar (1980). They were persons who (1) were able to verbally express key cultural information; (2) appeared to be representative of

the community; (3) had the time to spend with the researcher; and (4) had good rapport with the researcher.

Because there are cliques and groupings based on geographical proximity, one key informant was chosen for the area of Macedonia-Grove called Macedonia and another for the Grove locale. These women proved to be invaluable both in terms of the data they provided directly and in the increased access to other informants which they provided through informal referrals and introductions. Key informant interviewing is an effective way to check, expand and evaluate data gathered through participant observation.

Interviews with other members of the community ranged from informal conversations to structured sessions utilizing the focused interview guide. Likewise, the interviews varied in depth and breadth of content. Participation in and observation of both routine and special events in the community provided rich ethnographic information. Participant observation and informant interviewing as key methods of data collection will be described more fully in the next chapter.

At this point it is important to emphasize the wealth of information that was collected through these methods. The qualitative data gathered through these standard ethnographic methodologies was essential to the formulation of the focused interview guide described earlier in this chapter. The administration of this structured instrument generated quantifiable data which not only supplemented but also verified and challenged various aspects of the qualitative data. Thus, the data set was made more complete and accurate by the use of multiple data generating methodologies. Furthermore, the use of a standardized

scale within the focused interview guide allowed for cross cultural comparisons and added to the generalizability of the findings.

In summary, the examination of cultural behavior through a variety of approaches adds to the reliability, validity and comparability of the data. Thus, both qualitative and quantitative methodologies were employed to test the research hypotheses.

CHAPTER III A NATURAL HISTORY OF A FIELD EXPERIENCE

The following accounts of the fieldwork experience offer the reader a glimpse into my journey of discovery as I moved from using a wide angle lens, as Spradley (1980, p. 56) refers to it, to a more narrow focus for my field research. This overview both elaborates on the data collection strategies discussed in the preceding chapter and sheds light on special issues and constraints encountered in the fieldwork endeavor. A discussion of these special issues in the fieldwork process will be followed by a chronology of the three phases of the two and one-half year formal fieldwork experience.

Special Issues in the Fieldwork Process: Reciprocity and Commitment Beyond the Fieldwork Period

McCall and Simmons (1969) contend that it is important for the researcher to be aware of and explicitly state her/his biases, especially as they relate to the research endeavor. As a firm believer in patients/consumer rights, I felt strongly that the fieldwork associated with this research be characterized by reciprocity in aid, support and open communication. I tried to reciprocate the concern, knowledge and encouragement that the women in the community offered me during the two and one-half years of fieldwork by providing them with certain skills, information and services.

I served as a culture broker with the medical system by helping people with referrals to appropriate health and social service agencies, interpreting medical information for them (especially when they or their relatives were hospitalized) and advising them on common health problems--i.e., what to do for head lice. I tried not to confuse my role as a researcher with my role as a nurse but at times this role conflict posed thorny ethical dilemmas. For example, when women clearly demonstrated misinformation regarding hypertension during the structured interview, I felt torn between providing correct information and thereby contaminating my research and not correcting misinformation and thereby possibly contributing to the informants' ill health. I directly intervened only in those cases where the misinformation led to harmful practices. However, I did not undertake the overwhelming task of re-education of the entire research community during the fieldwork process.

After the fieldwork was completed, I worked with women in the community to organize hypertension education and screening programs to be held at local churches. As part of this effort, I trained several women in the skills of blood pressure measurement, the techniques of organizing and implementing community programs and the harnessing of available human, financial and educational resources.

The reciprocity issue created certain difficulties for me when it was time to leave the field. My personal commitment to individuals and groups within the community strengthened resolve not to be like many other researchers who had used the community for their own gains and then disappeared, never to be heard from again. Thus, I have maintained my relationship with the women with whom strong bonds had been

formed, continued my participation in significant community events, i.e., the dedication of the new community center, and remained an informal source of health care information. Perhaps over time some of these involvements will lessen. However, the commitment to reciprocity does pose practical problems in the resolution of the fieldwork process.

The following description documents the fieldwork activities as they unfolded in three distinct time periods. The first phase which lasted nine months (3/81-12/81) consisted of entrance into the research community and the establishment of a clinical care-bonded field rapport. Phase two (1/82-12/82) was characterized by intensive participant observation which yielded extensive ethnographic data and led to the development of working hypotheses. During the third and final phase of the formal fieldwork experience (1/83-9/83) a focused interview guide was constructed and administered, further data were gathered by participant observation and preparations for learning the field were accomplished. The postfield period (10/83-12/84) consisted of data analysis, the dissertation write-up and continued contact with several key community residents (Table 3-1).

Phase 1: Entrance into the Community and the Development
of a "Clinical-Care-Bonded" Rapport (3/81-12/81)

I initially became involved with the research population when I took a part-time job as the Clinic Coordinator for a small medical facility located in the rural community of Macedonia-Grove. A complete description of this community will be discussed in the next chapter. The role of Clinical Coordinator seemed not only appropriate to my

Table 3-1. Stages of the fieldwork process

	Sample	Focus of inquiry
<u>Stage 1 (3/81-12/81)</u>		
Entrance into community development of clinical care bonded rapport	All members of black community primarily those who attended health clinic	1) General beliefs, attitudes, and practices related to health 2) Social networks
<u>Stage 2 (1/82-9/83)</u>		
Participant observation in community events; Development of working hypotheses; Key informant interviewing	Black women in the community especially those in hypertension group and in older women's quilting group	1) Genealogies 2) Sources of health information 3) Health attitudes, beliefs, and practices both general and specific to hypertension
<u>Stage 3 (1/83-9/83)</u>		
Construction and implementation of focused interview guide; Attendance at national conference on black women's health issues	Black women--generational groupings and age cohorts	1) Sources of health care information 2) Health attitudes, beliefs, and practices both general and specific to hypertension
<u>Post Fieldwork (10/83-12/84)</u>		
Data analysis; Dissertation write-up	Maintenance of contact with key informants and 6-8 other women in research community	1) Generalizability of findings to other communities

previous training and experience as a registered nurse and director of a woman's clinic but also suitable for researching the health care attitudes and beliefs of a rural, primarily black community in the South. My job responsibilities included supervising a volunteer medical staff for a weekly clinic open to community residents for general health problems. Liaison with and referral to other medical facilities and social service agencies was an important aspect of my nursing role.

During the nine months I worked at the clinic, I became familiar with many of the community residents who used the clinic for their primary health care and was seen by them as someone they could turn to for help with a variety of problems. Rapport was easily established with the clinic patients and their families. This was demonstrated openly by affectionate embracing whenever I saw patients either in the clinic or community setting. Whenever a significant time elapsed between contacts, those with whom I had established good rapport would greet me with a hug and a statement about how much they had missed seeing me.

The development of this strong "clinical care bonded" rapport was most helpful during the more formal aspects of the research, especially in phases two and three of the fieldwork. It afforded me access to community residents in social contexts other than the clinic and opened doors to significant community events. I had established a social role that legitimized a kind of information gathering behavior--especially in regards to health concerns. Though community residents were reluctant to share personal information with a fellow community member who worked at the clinic, fearing that "everybody in the community will

know my business," they expressed a feeling of "safety" and "security" in revealing personal matters to me. The safety of revealing information to an outsider, and especially one in a helping role, allowed me access to information that other members of the community were not aware of. Thus, my role as a "clinical" researcher greatly aided my fieldwork endeavor.

Although I was extremely busy in my role as Clinic Coordinator during the weekly medical clinics, I did manage to interview many patients informally regarding their health beliefs. At this point in the research my questions were broad, general inquiries into patients' beliefs about the causes, diagnosis, cures, and prevention of a wide range of health problems. I also gathered a great deal of information on social networks, daily routines, and power structures of the community. The data gathered during this period helped me narrow my focus and define more precisely my research problem.

To summarize, the first nine months in the community, I was in the role of participant observer, but I was limited by my role at the health clinic. Although important data were gathered and a clinical-care-bonded rapport was established during this time, there were certain constraints that my role as the Clinic Coordinator imposed on the research. On a pragmatic level there was a problem with limited time, given other commitments to school, work, and family obligations. The responsibilities of the job became so overwhelming that my work hours increased from 10 per week to 30 per week. I found myself having less and less time available for non-clinic related work, i.e., my research. Furthermore, because the clinic was run by crisis management, there always seemed to be an urgency about the work

involved there. I was so busy participating that I had little time to observe. Clearly, there was a role conflict between my functions as researcher and Clinic Coordinator.

A second constraint on my research that the job created was the tactical problem of being identified with the clinic. As I became more familiar with the community and interacted with residents who did not utilize the clinic, I learned that there were some negative feelings about the clinic. These feelings stemmed from a variety of sources: personality conflicts with staff, perceived needs of the community not being met, feelings that health care there was inadequate, and lack of community involvement in the clinic's decision making Board of Directors. I began to wonder if being affiliated with the clinic was ultimately going to limit my access to the community.

Gradually, I came to feel that there were more constraints than advantages to continuing my affiliation with the clinic. Thus, after nine months, I discontinued my role as Clinic Coordinator and began to focus on my role as researcher.

Phase 2: Participant Observation and the Development
of Working Hypotheses (1/82-12/82)

In the second phase of research which lasted 12 months, I became involved in traditional ethnographic fieldwork. Agar characterizes the ethnographer as assuming a learning role, having long term intensive personal involvement with the research community, looking at phenomena from a holistic perspective, and searching for patterns among the multitude of data collected. These conditions accurately describe my research efforts during this period. I travelled by car to the

research community several times (3-4) each week. Although it may have been preferable to immerse myself totally in the community by establishing residence there, economic and familial constraints dictated that I remain in University Town and commute to the research community.

Commuting to rather than living in the research community both offered benefits and imposed constraints. Commuting allowed me time to reflect on the day's events and make some sense of what I had observed. Commuting also gave me the opportunity to give community residents a ride into University Town. In addition to serving as reciprocity for their help in my research endeavor, this transportation service provided a context for significant data collection. Often important data were revealed during the trips into town which did not come out in other contexts. Additionally, living outside the community minimized the reactive effects that a researcher's presence often has on the research site. Thus, there were apparent benefits of my non-residence in Macedonia-Grove.

There were, however, limitations and problems created by living outside the research community. One problem encountered by commuting to rather than living in the research community was created by living in two worlds simultaneously. The culture shock one experiences when entering a culture different from one's own was experienced to some degree everytime I entered and left the research community. Often the impact of the intensity and severity of the problems facing people in the research community made it difficult for me to drive back to University Town and share pre-arranged frivolities with friends. How could people joke and carry on when only 20 miles away others were

dealing with life and death crises? How could I deal with someone from the research community threatening suicide when I was in the middle of studying for comprehensive exams? I felt as though I was constantly shifting gears (between research and school, between research and family, between different value systems, and between different roles and statuses). At times this activity created a physical and emotional strain on me.

Secondly, the limitations on my ability to witness all the significant aspects of life in the research community were, of course, increased by my residence outside the community. I never was faced with having to make it through a day, week, month, or year in the community--dealing with the many obstacles created by poverty, geographic isolation, poor health, and racism. On the other hand, I never truly experienced the intense joys brought by the close kinship and friendship bonds between members of the community as they shared in mutually enjoyable activities. On both accounts, I feel a loss--but one which was unavoidable given my personal responsibilities and needs. Thus, there were both advantages and disadvantages in living outside the research community. I tried to maximize the advantages and minimize the disadvantages in order to optimize my data collection.

The primary technique employed during the second phase of my continuous research interaction with the field situation was participant observation. Attendance at church services, weddings, funerals, sewing circles, exercise groups, fund raising events, family reunions, and other significant community activities provided me with descriptive data and insights about the community in general and the members' attitudes, beliefs, and values about their health in particular.

Focused observations were recorded in field notes as soon after the event as possible, usually within several hours. Additionally, reactions and feelings regarding the fieldwork process were recorded in my personal journal.

Through participation in an ongoing community based hypertension group, I greatly enriched my knowledge base about the health attitudes, beliefs, and practices of women in the research community. Because of its significance, I will describe the hypertension group in some detail.

The Macedonia-Grove Hypertension Group

The hypertension group initially began as a pilot project of the local health clinic during the final week of my tenure there as Clinic Coordinator. My task was the design and implementation of a program that would educate group members regarding the risk factors related to high blood pressure so that behavioral changes could occur. In part, this goal was determined by responses to a community needs assessment conducted several years earlier (Albert et al., 1975) and in part by the specifications of a small grant that had been obtained by the clinic for this project.

The group, which met weekly, was comprised of 15-20 women, all of whom had been diagnosed as hypertensive by a physician and most of whom were obese. Each group session began with a blood pressure measurement and weight recording for each woman. During the first session, it became apparent that the group members were primarily interested in weight loss and secondarily concerned with hypertension control. Since group members seemed motivated to learn about weight reduction,

the first six sessions were devoted to various facets of healthful weight control technique. Activities related to this included a group discussion of why and under what circumstances members indulged in overeating; an exploration of weight reduction plans that employed behavior modification techniques and helpful dietary plans; cooking demonstrations of ways to prepare traditional foods with less cholesterol, sodium, and fat; a session on menu planning; and a collection and exchange of low calorie, healthful recipes.

It was possible to include a session about weight control, education regarding sodium as a risk factor in hypertension. A card sorting game was introduced to impart knowledge regarding the sodium content of commonly consumed foods and drinks. A Thanksgiving dinner for the community was planned and prepared by group members using principles covered in group discussions and demonstrations. Through this event, the group members graphically demonstrated to the 85 community members in attendance that nutritionally sound menus could also taste good.

Exercise was gradually introduced as an excellent form of weight control, stress reduction, and cardiovascular workout. After several exercise sessions, group members enthusiastically suggested that the "exercise class," as it was renamed, meet twice each week to maximize its benefits. Thus, after three months, the hypertension group evolved into an "exercise class" which met twice weekly for the next one and one-half years.

Although I was intensely involved in the activities of this group during this time, I was able to glean an enormous amount of data from group discussions, conversations between and with group members, and

informal observations. This data were recorded in field notes soon after the observation. Participation in this group further strengthened my clinical-care-bonded rapport with both the women in the group and other community residents. This legitimization was most helpful during phase three of the fieldwork process. My identity with the "exercise class" afforded me easy access into homes of women whom I previously had not met. Thus, participation in the ongoing hypertension group both yielded important data and strengthened my rapport with members of the community.

Key Informant Interviewing

In addition to participant observation, key informant interviewing yielded important data that contributed to the development of the working hypotheses crucial to the next phase of the fieldwork process.

Phase 3: Construction and Implementation of a Focused Interview Guide and Continued Participant-Observation (1/83-8/83)

Using data gathered through clinical nursing experience (phase 1), participant observation (phase 2) and a review of relevant social science and medical literature, I constructed an interview guide designed to test the working hypotheses (see Appendix). This interview schedule was subjected to both a professional and patient review process, as mentioned in the preceding chapter.

Use of an Indigenous Field Assistant

A field assistant from the research community was hired for a four month period (3/83-7/83) to assist in this structured collection

of data. She was a 25 year old college graduate with a major in sociology who therefore had a basic understanding of research design and data collection. Training of the field assistant consisted of explaining the research design, going over each question with her to insure understanding of the intent and content of the item, observing her doing several interviews and discussing problems encountered during independently administered interviews.

Fifteen weekly meetings with this indigenous interviewer provided a good feedback loop which insured that the questions were getting the desired data. It also served as an opportunity to uncover deletions, errors and incomplete responses which could then be corrected or supplemented the next week. The importance of confidentiality, which had been identified as a community concern during participant observation, was reinforced with the field assistant.

The community field assistant also provided access to an age cohort with which I did not personally have a great deal of rapport previously established (i.e., teenagers). Therefore, in addition to being time effective, the use of a community field assistant broadened the qualitative data base and improved the previously limited access to an important age cohort. The interviews were divided evenly between the two interviewers based on previously established rapport with the particular interviewer. The indigenous field worker completed 50 interviews, I completed 46 interviews.

Time and Setting of the Focused Interview

Women to be interviewed were personally contacted by telephone or in person by one of the interviewers. They were asked to participate

in a study about high blood pressure that the researcher was conducting. No one refused to be interviewed. On the contrary, most were eager to participate. A mutually agreed upon time was set up when the interview would take place. Although occasionally subjects forgot the appointment and were not home at the agreed upon time, the scheduled time was generally adhered to. Almost everyone was interviewed in her own home, but three women were interviewed at a relative's or friend's home.

The home environment was a comfortable one for both the informant and interviewer, but occasionally crying babies or curious neighbors would create distractions. The interview would be discontinued until there were no further distractions. Quite often the data obtained during the distraction was worth the delay! Furthermore, other data could be obtained through observation, e.g., watching women cook adding lots of salt.

Interviews lasted from 40 minutes to three and one-half hours. The interviews of older women tended to last the longest. They seemed thrilled at the opportunity to share their knowledge and ideas with a young person who was interested in them and their meaningful life experiences. Both interviewers agreed that the richness of detail provided by the older women greatly enhanced the research endeavor. The shortest interviews were with the teenagers who perhaps because of their limited life experiences had less additional information to share.

Interviews were not tape recorded. Key informants from the community felt that this recording device might intimidate subjects and perhaps seriously interfere with their responses. Responses to

questions on the focused interview guide were recorded in the space allocated for them. Additional data and verbatim responses were recorded by hand on the back of the interview protocol by the interviewer. The nurse researcher reviewed this additional qualitative data and added it to the field note records.

Participation in the First National Conference on Black Women's Health Issues

While administering the focused interview guide, I continued to collect data through participation and observation in community events (as in phase 2). In addition, I was afforded the opportunity to place my data in a larger cultural context through participation on a planning committee for the First National Conference on Black Woman's Health Issues held in Atlanta, Georgia, in June, 1983. From exposure to black women from urban and rural areas across the United States, of differing socioeconomic classes and different educational backgrounds, I broadened my knowledge base regarding black women's health concerns and experiences. I was able to note which experiences were shared by all black women and which ones varied according to the variables noted above. This understanding was furthered by attendance at the conference itself where 1,800 black women gathered to share their concerns.

My experience as an outsider and minority (one of 15 white women) provided new experiences and insights. Unlike the research community where racial differences did not seem to hinder my acceptance, there was very vocal and articulate opposition to the inclusion of white women in the conference in general, and on the planning committee in particular. This exposure gave me some insight into the feelings

black women often experience in the white world. In summary, the information and insights gathered during the course of this conference broadened my perspective and provided data regarding the generalizability of my research findings from the study community to other black communities.

Leaving the Field (9/83-)

The final stage of fieldwork consisted of preparations for leaving the field. As was discussed earlier in the section entitled, "Special Issues in the Fieldwork Process," this task was difficult for me to accomplish. In addition to my own issues, the exercise group had become dependent on my facilitation.

Though I had tried for six months to transfer leadership of the exercise class to two group members who demonstrated leadership potential, I was unsuccessful in effecting this change. When I went away for an extended period of time, at the end of the structured interviewing phase of fieldwork, the group members did not meet on their own in my absence. Though they cited bad weather as an excuse for not meeting, it was evident that the group lacked a leader who was willing to take charge of the exercise group. Thus, the exercise class dissolved after one and one-half years of weekly meetings.

My own ambivalence vis a vis reciprocity coupled with the group members' dependence on my leadership made the task of leaving the field very difficult indeed. However, it was important for me to set limits, primarily for myself, and stay focused on the tasks involved with data analysis and the dissertation write-up. Thus, I politely declined

further involvement everytime a group member called and suggested that
"We really have to start the exercise group again."

When the new community center was recently completed and a director for the facility was hired, daily exercise classes were scheduled. Thus, after a lapse of almost a year the exercise group was rejuvenated by the community. My continued though limited involvement with the research community one year after the termination of the fieldwork experience testifies to the difficulty I experienced in leaving the field. The proximity of my own residence to that of the research site and the bonds which had been formed with the women in the research community made a complete break impossible.

CHAPTER IV
AN ETHNOGRAPHIC PRESENTATION OF THE
COMMUNITY IN PLACE AND TIME

A description of the major sociodemographic and ethnographic features of the research community will provide a context in which to interpret the research findings. Because the community is a microcosm of the larger culture to which it belongs, it serves as a useful focus for discovering cultural behavior and social relationships.

Through an appreciation of the representativeness of this research site, the reader will gain an understanding of the potential generalizability and applicability of these findings to other small rural black communities in the American South. The following description is by no means intended as an indepth community study as described by Arensberg and Kimball (1965). However, the population, economic, education, occupational, religious and social features of the study community briefly outlined below will provide a backdrop against which to view the research findings discussed in later chapters.

The Setting

Macedonia-Grove, a rural community in North Central Florida, was originally established as two separate farming communities in the 1880's. It encompasses a geographical area of 30 square miles and thus is more spread out than compact. Although it is located only 20 miles

from University Town, an educational and medical center with a population of approximately 115,000 in 1980, Macedonia-Grove still has the feel of a rather isolated and underdeveloped farming community. Travel along one of the four paved roads in the area (Figure 4-1) reveals planted acreage interspersed with clusters of houses and trailers. A ride down one of the many dirt roads that lead through wooded areas, pastures and fields eventually brings the traveller to more groups of homes. Thus, there are far more people living in the community than travelling the state maintained paved roads might indicate. A large percentage of the community residents live away from the heavily travelled paved roads.

A friendliness typical of many rural communities is evidenced by people waving as one passes on foot or by car. There is also curiosity about any "outsiders" who travel through the community on other than the state maintained roads. Particular attention is given to anyone with a prolonged stay in the community (i.e., more than one hour).

The community is generally quiet punctuated by sounds of barking dogs, playing children, an occasional tractor and passing cars. In community gathering places the usual sounds of people socializing are heard. On Sundays, songs and prayers emanate from one of the five churches.

Two Communities Become One

Sixteen years ago, the two small communities of Macedonia and Grove joined together for the purpose of consolidating human and economic resources. This merger occurred in order to raise funds to purchase land on which a community center for education and

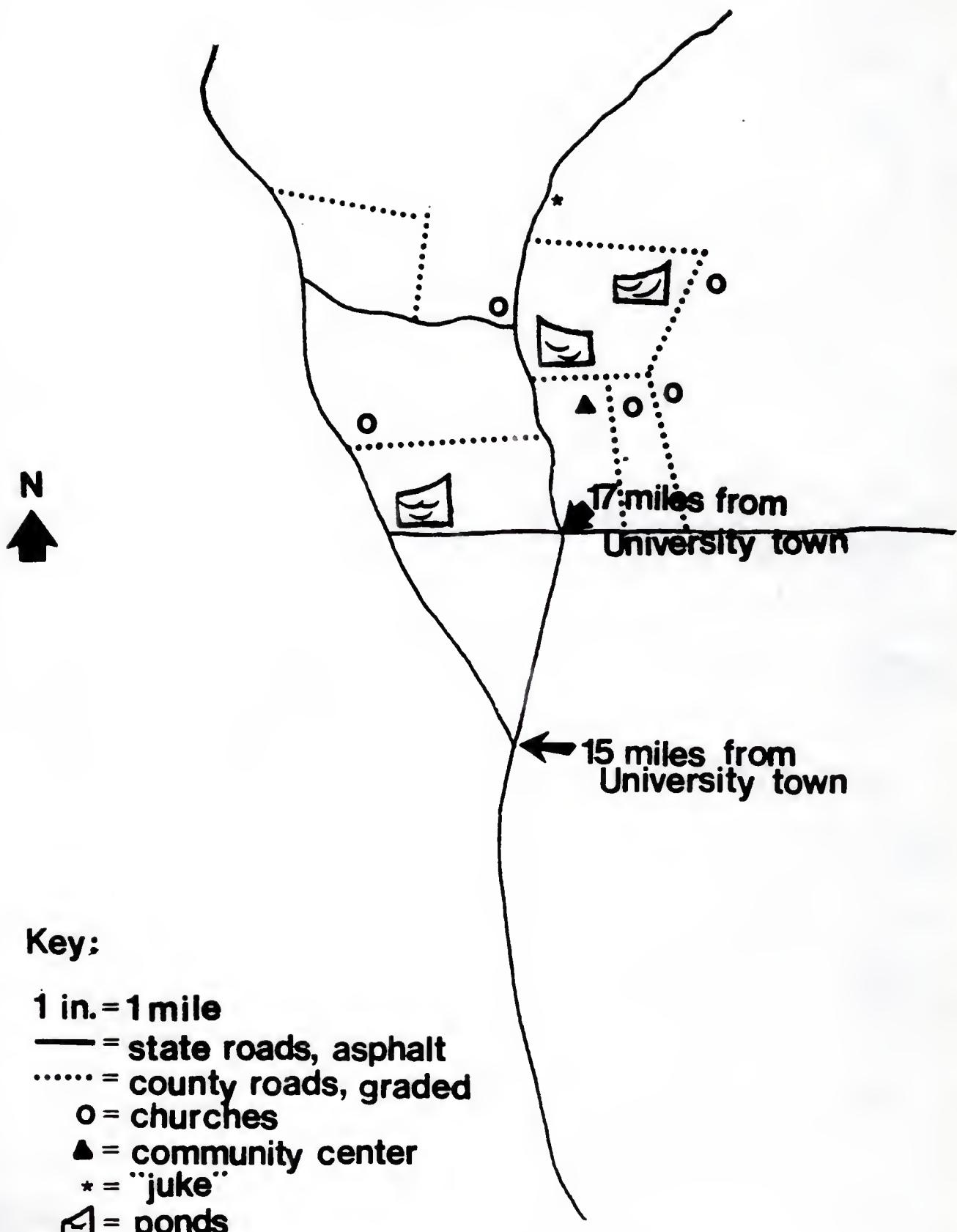


Figure 4-1. Map of Macedonia-Grove

recreational purposes could be erected. Through fund raising efforts, land was purchased and a building was moved into the community. However, within several years vandals had destroyed the old house used as the community center. A new center constructed by community volunteers has just been completed. Several recreational and educational activities have already been scheduled there.

The people of Macedonia-Grove consider it a community although there is no official recognition via county, state or national mechanisms that this entity exists. For example, the postal routes are based in two different post offices--one in University Town, the other in a small town several miles from Grove. Unfortunately, the U.S. Census Bureau does not consider Macedonia-Grove an entity (i.e., it is unincorporated). The community cuts across census tracts and enumeration districts. Thus, obtaining precise demographic data was most difficult. The following profile was derived by extrapolation.

Population

The total population is 1,317; 43.4% or 573 of these are black. Women make up 57.4% of the total population, thus numbering 678. There are approximately 288 black females in the community. Of these, 218 are 13 years old or greater, the eligible age category for this research. (See Tables 4-1 to 4-3 for more complete population statistics.)

Income Level

Macedonia-Grove is located in a poor, rural area. Thirty-four percent (34%) of the families residing there are below poverty level.

Table 4-1. Population of Macedonia-Grove (race by age)

Age	Black	White	Total
< 5	51	42	93
5-17	160	171	331
18-64	295	474	769
65+	67	57	124
Total	573	744	1317

SOURCE: U.S. Census Bureau Report (1980).

Table 4-2. Population of Macedonia-Grove (sex by age)

Age	Male	Female	Total
< 1	20	8	12
1-2	15	25	40
3-4	16	17	33
5	12	12	24
6	7	12	19
7-9	35	34	69
10-13	63	50	113
14	12	12	24
15	13	14	27
16	15	12	27
17	17	11	28
18	10	13	23
19	9	13	22
20	12	9	21
21	12	14	26
22-24	34	37	71
25-29	67	69	136
30-34	43	48	91
35-44	73	90	163
45-54	65	52	117
55-59	21	40	61
60-61	10	11	21
62-64	11	6	17
65-74	33	43	76
75-84	22	17	39
85+	4	5	9
Total	639	678	1317

Mean age = 27.6 years

SOURCE: U.S. Census Bureau Report (1980).

Table 4-3. Demographic profile of research community

Total population of community	1,317
Total black population of community	573
Total female population of community	678
Total black female population of community	288
Total black female population of community by age:	
< 13 years	= 70
13-20 years	= 31
21-35 years	= 78
36-59 years	= 74
60+ years	= 35

Obtained through extrapolation from U.S. Census Bureau Report (1980).

The poverty threshold for a family of four was noted in the U.S. Census materials as \$7,412 annual income. In addition, many of the elderly in the community exist on Social Security benefits with a mean annual income of \$3,782. The mean income for families with children under the age of 18 years residing with them was \$10,527 in 1980. Female headed households fared less well with a mean annual income of \$7,589. The per capita income averaged \$2,714 annually. (See Table 4-4 for detailed income statistics.)

Employment

For those who were employed in 1980 the largest occupational categories were service jobs (which included custodial, domestic and road work) and farming, according to U.S. Census reports. There is little opportunity for income generation within the community itself other than through child care, nursing care of the elderly, transportation services and farm work. The majority of those employed commute to jobs in University Town where they work at one of the many hospitals, nursing homes, businesses, in private homes or at the University. They function primarily as custodial workers, nursing assistants, cafeteria service workers or domestics. A few occupy secretarial positions. Some commute to one of four nearby towns (each 10-15 miles from the research community) where they engage in factory or prison work. Many of the above mentioned jobs involve evening and night shift work. In nearly all young black families (aged 24-44) both the male and female work. Most blacks in this age bracket who did not work were incapacitated by medical problems (women) or because jobs were difficult to obtain (men). There appeared to be very few young female

Table 4-4. Income level of households in research community

Income	Percent	Households
< \$5,000	41.6	127
\$5,000-\$7,499	10.2	31
\$7,500-\$9,999	4.6	14
\$10,000-\$14,999	27.5	84
\$15,000-\$19,999	11.1	34
\$20,000-\$24,999	< 1.0	4
\$25,000-\$34,999	3.6	11
	Total	305

SOURCE: U.S. Census Bureau Report (1980).

heads of household who received Aid to Families with Dependent Children (AFDC). A more typical pattern was for the young woman to work, leaving family or friends to care for her children during working hours.

Land Holding and Land Usage

Most of the people in the research community live on land that has been in their families for several generations. This heir land is passed down from one generation to another. Thus, one is likely to live in close proximity to one's siblings, parents, grandparents, aunts, uncles and cousins. Many of the families own large amounts of acreage (40-80 acres) which is currently worth between \$2,000 and \$3,000 per acre. However, there is little readiness to sell this land because community residents feel strongly that this land belongs to the next generation and thus should be passed on to them.

Some residents have hogs and cows but in general the land is used for agricultural purposes rather than for the production of livestock. Most households plant large gardens for personal consumption as well as acreage for income generating crops such as tobacco, peanuts, watermelon, corn, beans and peas. Neighbors and kin often exchange produce from these plots thereby supplementing their own supplies. Fishing in nearby ponds and lakes provides additional food supplies. Hunting, once a popular means for obtaining meat, has diminished considerably in the black community of Macedonia-Grove.

Housing

The U.S. Census Materials report that the median value of housing in the Macedonia-Grove area is \$16,500. Housing features of note are age of house, type of construction, plumbing, electrical heating, cooling and kitchen facilities. Nineteen percent of the houses were 45 years old or more; 46% were at least 25 years old. Mortgage payments for housing, then, are concerns for approximately one half of the households (Table 4-5). A majority of the houses (64%) are constructed from wood. This type of building material was used in all of the older homes. Most of the older community residents live in wooden homes.

Trailers, owned or being purchased by 25% of the community residents, are inhabited primarily by young adults. Heating is primarily by room heaters (55%) and cooling is accomplished through the use of fans (92%). Most of the homes with central heat (34%) and central air (13%) were trailers. All community residents have a stove and refrigerator. Fifty-five percent (55%) have a separate freezer for storage of food. During the spring and summer months foods are frozen for consumption throughout the rest of the year. There were 15% of the population who do not have hot water facilities or complete working indoor plumbing (same respondents). Everyone has electricity, television and radio. Ninety percent (90%) have a telephone. (See Table 4-6 for more complete data on facilities.)

Transportation

Transportation is a critical problem as demonstrated by the U.S. Census report that 32% of the population had no access to a vehicle.

Table 4-5. Age of houses in Macedonia-Grove

Age of house	Percent	Total number of houses
> 45 years	18.5	56
35-44 years	7.6	23
25-34 years	20.2	61
15-24 years	24.5	74
10-14 years	14.6	44
6-10 years	10.9	33
< 5 years	3.6	11
TOTALS	99.9	302

SOURCE: U.S. Census Bureau Report (1980).

Table 4-6. Housing: Construction and facilities (obtained from community survey)

	Percent of respondents	Total number of houses represented
Housing (Total number = 96)		
Material		
Wood	64	62
Trailer	26	25
Concrete/brick	10	9
Heating (primary source):		
Fireplace	11	11
Room heaters	55	52
Central heat	34	32
No heat	< 1	1
Cooling:		
Fans	92	88
Central air	13	12
Air conditioning units	4	3
No cooling	4	3
*Multiple sources used		
Kitchen facilities:		
Stove	100	96
Refrigerator	100	96
Freezer (separate)	55	52
Hot water facilities	85	81
Other facilities:		
Electricity	100	96
Complete working indoor plumbing	85	81
Television	100	96
Radio	100	96
Telephone	90	86
Washer	53	50
Dryer	36	34

Obtaining rides to nearby towns for shopping and/or medical appointments is particularly problematic for the elderly. Often, they will pay a neighbor \$10.00 round trip for this service if one of their family members is not available. A contribution for gas is usually made if a family member performs this function. There is a minibus service to University Town available one day per week but this is seldom utilized due to inconvenient scheduling.

Educational Facilities

There are no longer any schools in the research community. Up until 30 years ago there was an elementary school in Grove. When that school no longer functioned, students commuted to another nearby (8 miles distance) rural community to attend school. Twelve years ago, as part of the school desegregation program, students from Macedonia-Grove began to be bused into University Town for their elementary, middle and high school experiences. Therefore, many of their classmates reside in areas up to 30 miles from the research community and thus are not readily available for contact outside the school setting.

Religious Facilities

There are five churches in Macedonia-Grove where blacks attend services, prayer groups, choir practice and other community functions. The prominent religious sects are Baptist, Holiness, and Methodist. Regular church services are held twice monthly on either the first and third or second and fourth Sundays. The choirs from all five churches get together once each month for a choir union. In addition, members from one church will participate in special services at other

community churches. One such occasion is Women's Day--when the women of the churches plan and execute the entirety of the church service from ushering to preaching, reading, reciting and singing special selections. Often, women from other congregations in the community are invited to participate in these services. There is usually an ample meal served by the women of the sponsoring church after the services. In general, attendance at church is most regular among the elderly, women and young children. Young and middle aged men do not consistently participate in church services.

Shopping Facilities

There is one small general store located in Macedonia where one can purchase sodas, candy, bread and other "spur of the moment" items. This store is not readily accessible to those who live in the Grove area. Grove residents frequent a convenience store in a nearby town (3 miles) for incidental items. The majority of the community's shopping is carried out in University Town where prices are more economical and selection is more complete. Likewise, medications and other medical supplies are purchased in University Town because there are no drug stores in Macedonia-Grove.

Recreational Facilities

The only buildings other than residences and churches are the "juke," a hang-out where adolescents and young adults gather to socialize and the community center which has just been completed, as mentioned earlier.

There is a community park where football, basketball and baseball games are played and where youths "hang-out" with their peer groups. There are no other recreational facilities, e.g., bowling alleys, movie theaters, skating rinks, etc., available in Macedonia-Grove. The closest facilities for these activities are in University Town. Television, which is a major source of entertainment, is limited by reception of only two channels compared to 10 or more channels available in University Town.

Health Facilities

Seven years ago, a small health clinic which had been operating in an adjacent community moved to Macedonia-Grove. This clinic, staffed primarily by volunteer health care providers from University Town, offers low cost primary health care to community residents one evening per week. The utilization of the clinic's services by the community has been erratic. Very few of the people of Macedonia-Grove rely exclusively on this clinic for their formal health care needs. Most retain a relationship with a private physician or clinic in University Town as well.

Typically, the community clinic is used for acute illnesses and minor accidents that coincide with the once weekly clinic schedule, for blood pressure checks and prescription renewals, and for school and employment physicals. The clinic's limited resources necessitates referral or triage to medical facilities in University Town where more comprehensive diagnostic and treatment services exist. Transportation and economic difficulties often create barriers to follow through on these referrals.

There are no practicing healers, i.e., root doctors, faith healers, midwives or prayer ladies in the community at this time although each of these practitioners existed there in the past. Neither do the public health nurses visit the community now as they did as recently as 10 years ago. Community residents voice sorrow over the loss of this visiting nurse service, but do not express sadness over the disappearance of the other healers listed above.

Other Community Based Services

Though it is considered an outreach area for University Town-based community agencies (e.g., the library mobile unit stops there once per month, surplus commodities are distributed there by another agency, university fraternities and sororities occasionally sponsor recreational events for community children) Macedonia-Grove has few formal community based services and remains relatively undeveloped with regard to health and social services. Many residents of University Town, for instance, have neither heard of Macedonia-Grove nor know where it is located or what life in that area might be like. Given the proximity, this lack of knowledge among University Town residents and health professionals testifies to the isolated nature of Macedonia-Grove.

Macedonia-Grove residents hope that the newly built community center will enable them to attract more recreational, educational, health and social services into their community (i.e., a county sponsored daycare program might become available now that there is a facility to house the new project). However, at this point in time, the community residents of Macedonia-Grove rely on their network of

extended families and friends as informal support in times of need rather than on university-based community agencies.

Summary

This brief profile indicates that the research community is a relatively stable, economically depressed rural area which has historically relied on its own resources for coping with the challenges of survival. It is characterized by a subsistence economy with tremendous reliance on non-cash transfer of produce and services among kin and neighbors. Although a multitude of health and social services exist in nearby University Town, transportation difficulties, economic limitations, and other constraints often impose barriers to utilization of these facilities. Within the community, strong family ties and firm religious conviction promote the family and church as permanent institutions for support and strength. These coping strategies will become more apparent when we examine the research findings in subsequent chapters.

At this point, however, it must be emphasized that Macedonia-Grove is representative of a whole genre of communities. Its socio-demographic and ethnographic profile describes many other small rural communities in the American South (Hill, C, 1977). Therefore, research findings from this community will be applicable to other locales as well.

As a way of translating the economic, social, and demographic facts described above into a more concrete depiction of their meaning in terms of daily living, I have chosen a family study approach. The next chapter examines a typical weekday in the lives of three actual

women from Macedonia-Grove--an older woman, her daughter, and
granddaughter--as they move through their activities of daily living.

CHAPTER V
ORDINARY FAMILY LIVING WITHIN
THE ETHNOGRAPHIC PRESENT

Introduction

The following description depicts a typical weekday in the lives of three women from Macedonia-Grove. As such it is a statement of the behavioral realities expressive of the demographic, social, and ethnographic facts presented in the preceding chapter. Each woman is representative of the generation to which she belongs apropos her activities of daily living, chores and responsibilities, and recreational opportunities. To insure anonymity, the names of all people presented in this and all chapters that follow are fictitious ones. This synoptic overview equips the reader with a view of women's lives in the research community and provides a context in which to examine the socialization of succeeding generations. Especially noteworthy is the number and variety of family members and close friends who take care of the children in the course of a typical day. Child care activities are interwoven among many other tasks and responsibilities and are highly dependent upon the availability of female caretakers.

The Jones Family

Hattie Jones, aged 64 years, lives with her husband Wiley, 70, and her daughter Lenora's two daughters, Thawanda, 17, and Brenda, 26, on one of two main roads that traverse the community of

Macedonia-Grove. Three hundred yards away, Hattie's only child, Lenora, aged 42, lives with her husband, Leroy, 48, and her daughter Lakeisha, 9 years old. Lenora's and Leroy's two sons Leroy "Junior," 28, and Jerome, 24, no longer live in the community. Both young men joined the army after high school and eventually settled in distant states. Lenora's sixth child, Cheryl, 21, attends a college located 200 miles from her home. There is much fluidity of movement between the two houses, especially among the women and children, as the events of a day unfold.

Hattie: A Mother, Grandmother, and Great Grandmother, Aged 64

A typical day in the life of Hattie begins when she arises at 6 A.M. Like many rural people, she is accustomed to rising early to work in the fields. She no longer works outside the home but she awakens early and gets up to prepare breakfast for her husband, also an early riser, and her two granddaughters. Each granddaughter eats a piece of toast, gulps a glass of milk, and grabs a banana to take with her as she hurriedly departs from home. One must catch a school bus and the other rushes to meet her carpool for a commute to work in University Town. By 7:15 A.M. the house has calmed down. Only Wiley and Hattie are home. Hattie fries bacon, makes grits and brews some coffee. She warms up peas, leftover from last night's meal, and toasts several pieces of white bread. After breakfast, Hattie straightens the house, makes her own and Wiley's beds, and chats on the phone with her sister who lives 2 miles away. Telephone conversations serve the function of checking on the other's health and catching up on community news. At 9:00 A.M. both watch the Richard Simmons Show, a

popular past-time for all women in the community who are home during the day.

Hattie gets out her quilting and works on her latest project-- a lap cover for residents in a nursing home in University Town. Hattie's quilting group consists of 8-10 other women her age who meet weekly in each other's homes. Group members make articles for themselves, their families and friends, as well as undertaking community projects. They exchange ideas, materials, and skills while socializing and sharing in a communal lunch.

Today is Hattie's group meeting so she prepares a pan of cornbread to take with her. She warms up some leftover greens and macaroni and cheese for Wiley to eat in her absence. Her nephew, Zeb, who is also another member's grandson, arrives to give her a ride to her cousin's home where the quilting group is gathering today. She takes onions from her garden to share with her cousin in addition to the cornbread and her quilting project.

Hattie arrives at quilting group. There is much hugging and animated conversation as the members greet each other. One group member has brought her great grandbaby whom she is caring for today. All the members take turns holding and playing with the baby. A discussion ensues about all the different children each of them has "raised"--younger siblings, their own children, grandchildren, and now great grandchildren. Hattie talks about her newly born great grandchild who will be coming to visit during the family reunion. Meanwhile, the other women get out their quilting and begin to sew. They inspect each others work, give compliments and advice. Some, like

Hattie, have made lots of progress on their project since last meeting. Others have not.

After an hour or so, the hostess retreats to the kitchen and begins to ready the food. She warms the vegetables already prepared by some of the members, makes some kool-aid and sweetened ice tea to drink and gets the dessert out of the ice box. Several of the group help her with this preparation. Soon the meal is ready. It consists of summer squash, mustard greens, cornbread, stewed chicken and rice, and two large fried fish. The vegetables have been cooked with fatback so they are greasy and salty. The chicken and fish, likewise, are seasoned with salt. For dessert, there is pear pie made by one of the members with pears from her own tree and some brownies. The hostess has provided ice cream which most members eat along with a sampling of the pie and the brownies. Members in the group who report they are diabetic "only eat a little bit" (several bites) of each of the desserts.

Mealtimes conversation revolves around where the food was obtained, the cost of a variety of foods at different locations and recent picking and canning activities. After lunch, Hattie and another woman wash the dishes and put away the leftover food. Then they return to their quilting for another hour or so. Many of the women use snuff after the meal. Around 3:00 P.M. the women get ready to return home. Discussions of rides needed ultimately lead to a resolution in which everyone gets taken care of. Members do not necessarily go home with the same people who brought them.

Hattie returns home, checks on Wiley and then goes over to her daughter's house to visit. After a brief visit Hattie goes back to her

own house and begins preparation of the evening meal. Vegetables in particular are cooked over a low heat for several hours, so it is necessary to begin cooking in the late afternoon.

Soon, Hattie's nine year old granddaughter comes home from school on the school bus. After changing into her play clothes, she runs over to her grandparents' house. Hattie "watches over" her granddaughter while the child's mother naps. A neighbor boy comes over to play and the two of them run around the yard and in and out of both houses. When Hattie's teenage granddaughter comes home, she takes over supervision of the nine year old.

Hattie spends a lot of time each day sitting on her screened porch. From this vantage point she keeps track of the "comings and goings" of many of the community members. She knows who is in University Town shopping and who has gone to a nearby town to buy chickens. People beep their horn and wave as they pass by her house. She also uses this time to read from her Bible, an important activity that she engages in at least once a day.

By 6 P.M. most of the people in Macedonia-Grove who work day shifts have returned to the community. Thus, Hattie's granddaughters who live with her are home by the time supper is ready at 6:30 P.M. Hattie and Wiley are usually joined by the two older granddaughters for the evening meal. However, if the granddaughters like the food better at their mother's house next door, they might choose to eat there. Sometimes the teenager eats in both places. If someone is not home at suppertime, food is left on the stove so that the absentee can eat when he or she returns. Leftovers are usually consumed during breakfast or the noon meal the next day.

After dinner, Hattie and Wiley watch television for a couple of hours and then retire to bed early (9:30 P.M.). If the next day is expected to be more strenuous than usual, i.e., a trip into University Town or a holiday with much visiting and activity, the bedtime may be earlier.

Lenora: A Mother and Grandmother, Aged 42

Lenora's typical day differs a great deal from her mother's. Lenora works the night shift at a hospital complex in University Town. She is just returning from work when the rest of her family is waking up. She prepares breakfast and readies her nine year old daughter for school. After her "baby" leaves for school, Lenora goes to bed for 4-5 hours. Her husband works 12 Noon to 8 P.M. so their waking hours at home do not correspond much during the week. Lenora sometimes wakes up to prepare the noon-time meal for her husband. Otherwise, he "makes do" with leftovers from the night before.

Lenora eats "breakfast" when she wakes up and then does household chores--washing and ironing clothes for her children, husband and parents, sweeping, straightening and vacuuming the house. The television is usually turned on during this time. Watching the daytime "soaps" is a popular past-time in Macedonia-Grove. Lenora "keeps up" with several of these stories. A discussion of the recent happenings in the lives of these T.V. characters will be a significant part of Lenora's interactions with her co-workers later that evening.

Lenora begins the preparation of the evening meal in the early afternoon. Her style of food preparation is similar to her mother's and to the other women of the community--cooking over a low flame for

several hours. Usually, Lenora takes a nap during this time (4 P.M.-6 P.M.) leaving her teenage daughter in charge of "checking on the food." The evening meal is sometimes eaten with the entire family (including the husband and two older daughters, sometimes only her youngest daughter, sometimes only her husband). This seems to depend on the appetites, whims, and schedules of the various participants.

Lenora begins getting ready for work immediately after supper (8:30 P.M.-9 P.M.). She drives over to a cousin's house so that the two of them can ride into University Town together. Lenora is afraid to drive the 20 miles along relatively deserted roads alone at night. She and her cousin usually arrive one-half hour before they need to clock in because they "hate to be rushed." This early arrival also allows for socializing with other workers before their shift officially begins at 10:30 P.M.

Lenora works in the housekeeping department of the health center's medical college. This wing of the building is totally deserted during the evening. Lenora works in a pair with another black woman. Together they are a part of a team of six people who are responsible for cleaning a large number of laboratories, offices, lavatories, and conference rooms. Lenora stays busy most of the night. She hurries to finish her work by 4:30 A.M.-5 A.M. so that she can get together with other members of her team for the purpose of socializing and/or surreptitiously watching a television in one of the conference rooms. There, they take turns "watching out for the supervisor" who does not condone this use of work time. Work is officially over at 6:30 A.M. at which time Lenora meets her cousin and drives back to Macedonia-Grove.

Thawanda: A Daughter and Granddaughter, Aged 17

A typical day for Thawanda begins early since she meets the school bus at 7:15 A.M. She takes a 21 mile trip into a high school located in an exclusive section of University Town. This school is attended by many of the children of middle and upper class white professionals and business people as well as by blacks bussed in from various outlying rural areas and from other parts of the city. Twenty percent of the student population are black. Though there are not open hostilities between the racial groups, there is little real mixing of the two socially. Most of the black students eat together at lunch time and socialize primarily with other blacks. The same is true for white students.

Thawanda and her friends talk about the usual teen topics--boys, fashions, make-up and hair styles, recent parties, school work, and school events. They walk between classes together and usually sit with each other during classes. Thawanda socializes with some of her cousins who live outside the community but who go to the same school as she does. Since Thawanda does not have her own transportation, she is limited in her after school activities. She must catch the school bus back to the community or arrange for her sister to pick her up after work. Thus, Thawanda usually does not socialize with her school friends outside the school context.

An exception to this pattern is Friday night football and basketball games. Several of the Macedonia-Grove boys are on the high school football team so there is high participation among community members (adult and youth) at these events. At the games, Thawanda usually sits

with her school friends, though she gets a ride to and from the event with someone from the community.

On the weekends, Thawanda attends barbeques and other get togethers in the community. Some of these are multigenerational events such as family reunions, while others are limited to her peer group. Teen parties at private homes or at the community center and activities at the "juke" usually involve alcohol consumption, recreational drug usage, i.e., marijuana and cigarette smoking. Teen participation in such activities at family events is not sanctioned by the adults--especially those of the grandparental generation. This does not mean that these behaviors are not present on these occasions but rather that they are more discreetly participated in.

During community events there is much more interaction between the sexes in the teenage and young adult group than in the other age cohorts. (Middle-aged and older people tend to spend most of their time in sex segregated interactions at such gatherings.) Thawanda jokes with boys and girls who are her age or slightly older. She interacts little with adults except to bring her grandmother a plate of food or bring her grandfather something from the truck. Occasionally she plays with some of the babies or toddlers who wonder her way.

Thawanda's life has a more serious side as well. She wants to attend college like her two older sisters did. Thus, she is taking courses at high school which will prepare her for future study, e.g., computer programming, math, accounting. For the last two summers she has attended the University's Upward Bound Program which is designed to encourage black youths to achieve a college education. During that time she lived in a dormitory and greatly enjoyed the experience.

Like her older sister Cheryl, Thawanda looks forward to attending a state university where she hopes to major in business administration. She expresses ambivalence about leaving her family to attend college but appears comforted by the knowledge that other family community members have done so with no apparent problem.

When Thawanda gets home from school (around 3 P.M.) she has certain household responsibilities and chores. She "helps out" around her grandparents' house by dusting and sweeping. She "watches over" her mother's cooking and loosely supervises her younger sister. Thwanda drives her grandmother to a nearby store to purchase some food supplies. These activities are interspersed with watching the "soaps" on television. After supper in the evening, she does her homework, talks to her friends on the telephone, reads magazines, listens to music on the record player in her room, and grooms her hair. She usually goes to sleep around 11 P.M.

In summary, this synoptic overview of the ordinary weekday lives of three women from the research community provides a context in which specific health care beliefs and practices can be examined. The proximity of the three generations as they go about the activities of their daily lives provides an opportunity for much exchange of information, transmission of beliefs and attitudes, and modelling of behaviors. The specific attitudes, beliefs, and behaviors vis a vis health in general and hypertension in particular will be closely examined in the following chapter.

CHAPTER VI DATA ANALYSIS AND RESEARCH FINDINGS

A convergence of evidence was obtained by the different data eliciting techniques discussed in Chapters II and III. The qualitative data obtained through participant observation, informant interviewing, and secondary source review, i.e., fiction, were coded and analyzed independently of the quantitative data, i.e., the materials generated by the focused interviews and the demographic data gathered through secondary source review. This method of data analysis afforded the opportunity to supplement, corroborate, or correct impressions gathered by any one data source. The data set was thus made more valid and reliable by employing multiple strategies of analysis.

Qualitative Data Analysis

The copious field notes gathered during over 4500 hours of fieldwork in the research community were analyzed using a combination of techniques. Observations were first recorded in the field note record in chronological order. On a periodic basis, either weekly or monthly depending on availability of time and number of observations, the chronological record was xeroxed and then coded using the general coding categories listed in Figure 6-1. Specifically, each line of the narrative was examined in order to identify recurring themes and observable patterns.

Ethn = Ethnographic description

Hist = historical information
 Hous = housing
 Emp1 = employment/income generating activities
 Educ = education
 Rec = recreation
 Ch = church
 HC = health care
 Tran = transportation
 Shop = shopping
 CR = community resources
 ADL = activities of daily living
 Heal = healers

Dem = Demographic

Gen = genealogies	Function:	
Ntwk = networks		Chc = childcare
Fr = friend		Tran = transportation
Ch = church		\$ = financial
Rel = relatives		Err = errands
Nei = neighbor		Hk = housekeeping
CT = References to caretakers		
Fm = family members		
M = mother		
Gm = grandmother		
A = aunt		
S = sister		
C = cousin		
OF = other family member		
OC = others in community		

Figure 6-1. Complete chart of codes used in data analysis

Info = Source of Information

Ra	=	Radio	GEN	=	general info	Receiver
Tv	=	Television	SP	=	specific info	Who
Prnt	=	Print				Age
		MAG	=	magazine		
		NP	=	newspaper		
		BK	=	books		
		Bib	=	bible		
		Phlt	=	pamphlet		
Sch	=	school				
♀ rel	=	female relative				
		gm	=	grandmother		
		a	=	aunt		
		m	=	mother		
		cou	=	cousin		
		sis	=	sister		
		o	=	other female relative		
♂ rel	=	male relative				
		gf	=	grandfather		
		f	=	father		
		o	=	other male relative		
Dr	=	physician				
Nur	=	nurse				
nei	=	neighbor				
fr	=	friend				
phar	=	pharmacist				
min	=	minister/preacher				
Ch	=	church				
Dent	=	dentist				
hcw	=	health care work (relative or friend)				
chir	=	chiropractor				
Mdwf	=	midwife				

heal: Women as healers

CT	=	caretaking				
eld	=	elderly				
ch	=	child				
o	=	other				
Ctxt	=	context				
Func	=	type of caretaking function				
sick	=	tending to sick				
main	=	general maintenance				
info	=	information giving				
Rem	=	type of remedy				
herb	=	herbal				
hr	=	home remedy (other than herbal)				

Figure 6-1. Continued

Rx med = prescription medication (advice on)
 pract = practices
 otc = over the counter medication

HERB = Home & Herbal Remedies

Condition/remedy/mode of administration/information/age

REL = Religion & Health

C = causality
 F = fate
 Dr = Dr as God's instrument
 P = prayer
 R = ritual
 L = luck

DIET = Dietary Influences on Health

E = etiology/cause	Gen = general
P = prevention	Sp = specific
C = cooking techniques	
Fd pref = food preferences	

Wea = Weather Influences on Health

C = cold
 H = hot
 R = rainy
 L = lightning

HTN = Hypertension

Def = Definition
 Explan = Explanation
 # = Numerical parameters
 E = Etiology/cause
 C = cure/control/treatment
 P = Prevention
 Sx = Symptoms
 Refer = Referral to
 Conseq = Consequences
 + = Hypertensive
 - = Not hypertensive

Figure 6-1. Continued

Opler (1945) suggests that the identification of frequently occurring themes denotes "a postulate or position declared or implied, and usually controlling behavior or stimulating activity, which is tacitly approved or openly promoted in a society" (p. 198). Therefore, the field narrative was subjected to content analysis in order to discover both the general and specific health care beliefs, attitudes, and practices of the members of the research community. The source and mode of transmission of various health care information were also noted. In addition, general ethnographic and demographic categories were identified in order to describe the research community and place it within a larger context.

The xeroxed field record, thus coded, was then filed in folders labelled by the general headings in Figure 6-1. Coding became more specific as fieldwork progressed. As new themes emerged, new codes and more specific headings within existing codes were added. Thus, the analysis of the qualitative data was an ongoing process throughout the fieldwork process. Likewise, data collected from secondary sources, e.g., both fiction and nonfiction written by black women, were subjected to the same content analysis.

In addition to classification by content categories, field notes were xeroxed and filed in folders by age cohort, generation group, and family membership. Thus, the same piece of data might be filed in up to four folders. This system of data classification is comparable to coding procedures in the processing of standard Human Relations Area Files (HRAF) materials. This procedure facilitated an examination of the data by relevant groupings in order to test the hypothesis that

health care beliefs are transmitted from one generation to another by female relatives and other female members of the research community.

Process related data, e.g., feelings about role conflicts, ethical dilemmas, pros and cons of residing outside the research community, were recorded in my personal diary. These recordings were reviewed during the formal period of data analysis. Recurrent themes were identified by color coded highlighting, i.e., blue = reciprocity issues, green = rapport building, yellow = ethical dilemmas, and pink = fieldwork constraints. These color coded notes were reviewed for appropriate inclusion in the field narrative of this research report.

Quantitative Data Analysis

The quantitative data gathered through administration of the focused interview guide were analyzed with computer assistance using the Statistical Analysis System (SAS). A research evaluator who had previous experience in ethnographic as well as quantitative research methodologies was hired to write and run the program. Her assistance greatly facilitated the task of quantitative analysis. Simple frequencies were run on all subjects for the demographic, health locus of control, sources of health information, and hypertension variables delineated on the focused interview guide (Appendix B).

In addition, frequencies on the above named variables were run by age cohorts, by generation, and by diagnosis, i.e., hypertensive or non-hypertensive. An analysis of variance (ANOVA) and the Duncan Multiple Range Test were utilized to examine the data by educational level, age, generation, and diagnosis. The acceptable level of significance was determined to be .05.

Data were transferred from computer printouts to tabular charts in order to compare graphically the results obtained for different age cohorts, generational groupings, and family members.

Finally, the quantitative and qualitative data sets were combined in order to provide a more valid, reliable, and comprehensive reportage of the research findings. Examples of the complementary nature of the two data sets will be apparent in the following sections.

The qualitative and quantitative data sets were analyzed to determine the validity of the four interrelated hypotheses which guided the research endeavor. However, before examining the data related to hypotheses testing, it is important to ascertain the representativeness of the study sample. Therefore, the sociodemographic features of the research sample will first be presented. It is followed by the specific data relating to the transmission of health care beliefs, attitudes, and practices in the community of Macedonia-Grove.

Sociodemographic Research Findings

Demographics

As mentioned earlier, the sample for the focused interview included 96 black women from the research community who ranged in age from 13 to 85 years. This sample was comprised of 73 women who represented 23 family groups of three generations each. An additional 23 respondents were added to the sample in order to examine the data by four age cohort groups as well as by three generational groupings.

Family Structure and Childrearing Patterns

Fifty-eight percent of the respondents had been raised as a child by both parents, 28% by their mother alone, 10% by another female relative, i.e., grandmother or aunt, and 2% by a non-kin female member of the community. Only 2% had been raised by a male relative alone (Table 6-1).

When examining these data by age cohorts, one notices some differences among the groups. More young adults aged 21-35 years were raised by their mothers or single female relatives than by both parents whereas all the other groups including the teens had been primarily raised by both parents. This difference between age cohorts is even more marked when one examines the data for childrearing during the teen years (Table 6-2). All groups demonstrate less involvement by the father during the teen years but this pattern is particularly noticeable in the young adult age cohort.

Residential Stability

Data from the study sample confirmed the assertion that they represent a relatively stable rural-based population (Tables 6-3 to 6-6). Two thirds of the respondents had never lived away from the research community, while another 21% had lived away for less than 5 years. Of those who lived away from the research community (33%), most (23%) had lived in nearby rural communities during their younger years but had returned to Macedonia-Grove after a short absence.

One-half of the respondents stated that they left home between 21-30 years of age, while one quarter left in their teens, and one

Table 6-1. Who were you raised by as a child?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Both parents	58	63	71	44	62
Mother only	28	21	14	39	38
Female relative	10	11	15	6	0
Non-female relative	2	0	0	11	0
Male relative	2	5	0	0	0

Table 6-2. Who were you raised by as a teen?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Both parents	47	63	62	28	54
Mother only	37	21	24	50	46
Female relative	9	11	9	11	0
Non-female relative	4	0	0	11	0
Male relative	3	5	5	0	0

Table 6-3. Ever lived away from Macedonia-Grove (for more than one year)?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
No	67	52	62	67	92
Yes	33	47	38	33	7

Table 6-4. Of those who had lived away, for how long?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
1-4 years	21	34	54	22	7
5-10 years	11	10	4	11	0
10+ years	1	3	4	0	0

Table 6-5. If lived away, where?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Rural areas	23	31	20	16	5
Urban areas	10	16	18	17	2

Table 6-6. At what age did you leave home?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	3	0	0	0	23
15-20 years	24	63	5	33	77
21-30 years	52	37	76	50	0
Over 30	21	0	19	17	0

quarter after the age 30. Leaving home, however, may mean merely moving to a separate dwelling located on the same property of one's parents, "just down the road a piece." No one of those interviewed lived more than a couple of miles from their home of origin.

There is often fluidity of residences. A young woman might move out of her parents home and live with an aunt for awhile. At some later date she may live briefly with her grandmother but then move back to her parents home. It is this pattern, coupled with 40% of the respondents' reports that they were raised by a variety of female kin or para-kin, that supports the need to examine the influences of all female relatives as potential sources of health care information, attitudes, and beliefs. It is for this reason that additional respondents were added to the original sample of three generational family groups.

Educational Level

The educational level of the study sample varied by age group (Table 6-7). The older age cohort (60-85 years) completed a mean of 5.3 years. Most reported that they had left school for work due to economic necessity. The middle adults completed a mean of 11 years while the young adults attended an average of 12.9 years. Most of the teen group were still in high school so their education is still in process. (An average of 10.4 years has been completed to date.) Half of them plan to obtain more education at the junior college or college level.

Within families, there is a significant trend toward increasing educational levels across generations. No one in the second generation

Table 6-7. Mean education level (years)

Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
5.3	11.0	12.9	In process

had gotten less education than her mother and most of the third generation had gotten or are planning to get more education than their mothers. This finding has implications both for the types and degrees of exposure to health care information and for the ability to evaluate conflicting sources of information.

Work Outside the Home

Eighty-eight percent of the respondents have worked outside the home at one time. Of the 12% who have never worked, most were teenagers (Table 6-8).

The types of occupations varied by age cohorts (Table 6-9). The older adults had worked primarily as field hands and domestics in private homes. Most (95%) are retired now. The middle adults had worked or still worked mainly as domestics, institutional custodial workers, cafeteria service, and factory workers. Some worked as nursing assistants in hospitals and nursing homes. The young adults were employed in secretarial, receptionist, and sales work, though some worked as domestics. The teen group were primarily students. Those who were employed worked part-time in unskilled jobs such as field hands or fast food dispensers.

As demonstrated by Tables 6-8 and 6-9, there has been a trend from rural based employment for the older age cohorts towards work in the nearby urban area for the middle aged and young adult groups. Although more teenagers currently work in the rural areas as field workers, this is a temporary situation. The majority of teens (92%) expressed a desire to obtain a job in the city or continue their schooling.

Table 6-8. Have ever worked outside home?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
Yes	88	100	96	100	46
No	12	0	4	0	54
If worked, where?					
Rural	45	95	15	17	33
Urban	55	5	81	83	13

Table 6-9. Occupation by age cohort

Age	Occupation
60+	Field hands (60%); domestics (52%)
36-59	Domestics (51%); institutional custodial workers (36%); factory work (30%)
21-35	Secretarial (53%); saleswork (42%); domestic (32%)
13-20	Student (92%); fast food dispensers* (13%); fieldwork (33%)

*Part-time employment.

Among the younger generations of family groups, there was a definite trend toward higher paying positions. All the third generation subjects were working at jobs equal to or better than (in terms of prestige and money) those of their mothers and grandmothers. Thus, there is a definite trend toward more education and higher occupational status among the women in the community in general and within specific families.

Summary of Sociodemographic Findings

In summary, the sociodemographic data gathered from the focused interviews confirm the representativeness of the study sample. Like other members of the research community, these 96 respondents have spent the majority of their years living in a relatively stable rural area. Many of them (58%) have been raised by both parents. However, a significant number (40%) were raised by their mothers alone, female kin or para-kin. All of the respondents then continued to live within several miles of their childhood home.

As times have changed with both more economic demands and more available opportunities, members of Macedonia-Grove have migrated to the urban center, University Town, for education and employment. There is a demonstrated pattern within family groups and among age cohorts to seek higher levels of education and more skilled employment.

Thus, the quantitative data obtained through the focused interviews both confirm the qualitative description of the research community and attest to the representativeness of the study sample. Furthermore, it underscores the need to examine the differential effects certain variables, e.g., the effects of level of education,

or place of employment on the transmission of health care beliefs, knowledge, and practices. The following sections will present these influences in more detail.

Research Findings on Transmission of Health Information Practices and Beliefs

Section A: The Transmission of Health Information

Information about health and illness can be obtained from a variety of sources: friends, relatives, health care professionals, the mass media (movies, TV, and radio), and printed materials (newspapers, magazines, books, and pamphlets). The reader will recall that it was hypothesized that health care information, beliefs, and behaviors are orally passed from one generation to another by female relatives and other significant female members of the community.

A second related hypothesis has stated that there will be less reliance on female-based oral tradition as a source of health care knowledge in succeeding generations as a result of greater exposure to, and reliance on, other sources of health care information: i.e., radio, TV, magazines, newspapers, movies, books, schools, and contact with the medical system. It is noted once more that pertinent data regarding these two hypotheses were gathered by focused interviewing (subsection 1), participant observation (subsection 2), and a survey of popular black literature (subsection 3). How this folk health information base relates to the transmission of health care practices and beliefs will be reported in Sections B and C, respectively.

Subsection 1. Data gathered through focused interviewing

Respondents were asked directly during the structured interview from whom they got most of their information about health and illness. The responses of all 96 subjects taken together reveal the number one source of information to be a female relative, usually a mother or grandmother but sometimes an aunt, cousin, or older sibling (Table 6-10). However, when examining these data by age cohorts, significant differences among age groups emerge (Tables 6-11 to 6-21). The overall and particular findings are reported beginning with the older age cohort (60+ years). They are followed by a presentation of the findings on the middle aged, young adult, and teen age cohorts.

Older age cohort (60 years of age and older). The older age cohort overwhelmingly report (85%) that while growing up their mother or grandmother was the chief source of information, followed by the community midwife. However, doctors and nurses are now their major source of information. Most older women stated that they never saw a doctor until they were in their 40's or 50's. "I never went to a doctor when I was coming up. There weren't any around here" says one respondent. "My mother doctored on all of us. She knew just what to do," states another. A third respondent indicated that times were changing. "When I was a kid, I had the whooping cough. And my mama went out and got buds from the pine tree and fixed me right up. But now things are different. There's so much new stuff. You need to go to the doctor now." Many relied on herbal and home remedies passed on to them by their female predecessors for taking care of their own children.

Table 6-10. Major sources of health information as reported by all respondents (N = 96)

#1	Female relative
#2	Doctor/nurse
#3	Television
#4	Books, magazines, newspapers
#5	Teacher

Table 6-11. Major sources of health information by age cohort*

	Older adult 60+ years	Middle adult 36-59 years	Young adult 21-35 years	Teens 13-20 years
#1	Female relative, (85%) i.e., mother, aunt, grandmother	Female relative, (60%) i.e., mother, aunt, grandmother	Doctor (84%)	Television (69%)
#2	Midwife (52%)	Doctor (80%)	Television (79%)	Teacher (68%)
#3	Doctor/nurse (72%)/(41%)	Nurse (52%)	Books, magazines, newspapers (67%)	Female relative, (59%) i.e., mother, aunt, grandmother
#4	Bible (30%)	Television (50%)	Female relative, (60%) i.e., mother, aunt, grandmother	Nurses (39%)

*Multiple responses.

Table 6-12. How often do you read the newspaper?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Never	18	26	14	0	23
Daily	46	47	67	56	30
1x/week	23	16	14	39	46
1x/month	7	5	5	5	0
6x/year	2	5	0	0	0

Table 6-13. How often do you read about health in the newspaper?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Never	44	53	29	28	69
Daily	10	5	29	17	0
1x/week	30	22	33	33	23
1x/month	11	15	10	22	8
6x/year	1	15	0	0	0

Table 6-14. How often do you read magazines?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	38	79	29	6	8
Daily	7	0	14	6	8
1x/week	14	11	14	28	15
1x/month	30	11	29	50	70
6x/year	7	0	14	11	0

Table 6-15. How often do you read about health in magazines?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	53	89	43	22	46
Daily	5	0	10	6	0
1x/week	6	0	10	11	8
1x/month	24	11	19	50	46
6x/year	8	0	19	11	0

Table 6-16. How often do you listen to the radio?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	13	26	0	6	8
Daily	59	37	52	83	92
1x/week	22	37	43	6	0
1x/month	1	0	5	6	0
6x/year	1	0	0	0	0

Table 6-17. How often do you hear about health on the radio?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	59	63	57	50	69
Daily	10	16	10	6	15
1x/week	19	16	29	28	8
1x/month	7	5	5	17	8
6x/year	1	0	0	0	0

Table 6-18. How often do you watch television?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	2	0	5	0	0
Daily	81	74	81	83	92
1x/week	12	21	14	17	8
1x/month	0	0	0	0	0
6x/year	1	5	0	0	0

Table 6-19. How often do you hear about health on the television?

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Never	2	21	5	6	8
Daily	11	53	57	61	15
1x/week	51	21	33	28	46
1x/month	26	5	5	5	23
6x/year	6	0	0	0	8

Table 6-20. Types of health information obtained from television:

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Ads for health products	15	11	10	17	31
Exercise	53	57	58	44	46
Nutrition	12	11	19	6	8
Specials	12	5	10	17	15
FYI	50	42	58	44	62

Table 6-21. References on health in the home:

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
None	60	80	42	24	54
Encyclopedia	21	0	19	44	23
Health book	12	0	24	37	15
Pamphlet from doctor	7	0	15	6	15
Bible	7	15	5	0	0
Herbal compendium	2	15	5	6	8
Other	1	0	0	6	8
All	1	0	5	0	0

I had ten head of children and none of them saw a doctor till they were way grown. I'd just go out there in those fields, or in the woods and pull up one of the weeds my mama told me about. You know there's something out ther for just about everything that can go wrong. (Anna, age 72)

While this researcher was visiting Anna, her daughter (aged 44) who still lives with her went out back to pull up some poke salad for the ulcers on her mother's legs. According to Anna, who is diabetic, a tea made by boiling poke salad will heal her leg ulcers. Anna is blind now, so she cannot pick herbs and roots for herself. Her daughter seems to know about many of the herbal remedies but her granddaughter (aged 19) laughed and said she doesn't know about "those old timey things."

The midwife appeared to be a primary source of information about matters related to pregnancy and childbirth for many of the older women (52%). An interview with the community midwife revealed that she had gained most of her information from her mother who was an "herb doctor." She recited a number of herbal remedies that purportedly cured everything from "rattling in the chest" to "cooling the blood." Although a number of her remedies were specific to childbirth, i.e., ginger tea to ease labor pains or camphor to prevent engorgement, her repertoire definitely included remedies for common illness and conditions such as fever, colds, constipation, nosebleeds, and high blood pressure. Interestingly, though she spoke disparagingly of the younger generation "who are always running to the doctor" she cited her own doctor as the authority regarding her present health.

Although female relatives and the community midwife were the chief sources of health care knowledge during their earlier years, older

women report that doctors (72%) and nurses (41%) are now their primary sources of information related to health and illness. They speak in respectful tones about their doctors and view them as instruments of God.

The good Lord works through him (her doctor) to cure peoples. He (God) gives them the gift to heal. You better believe it. He (the doctor) does the Lord's work.

Just how much of such information as transmitted by health care professionals is actually understood remains open to question. One respondent, for example, when reporting to me what the doctor had told her just that morning, demonstrated a very confused and essentially incorrect understanding of her illness.

The doctor said that my sugar diabetes came cause an organ in my back quit working. It's not from starches or anything you eat, it's because the pancreas [sic] gets blocked. You need to eat sweets because you can use your sugar up and pass out. I need to keep candy with me everywhere I go. I always thought people with sugar diabetes weren't supposed to eat sweets, but my doctor said, no, just eat a little bit of them. Unless'n you feel like you're going to pass out. Then you eat a lot.

Nevertheless, the older women in Macedonia-Grove report that health care professionals in the clinic or at private physicians' offices are their main source of health information.

When asked to differentiate between physicians and nurses, the older women stated that they relied on the nurses for explanations of the doctor's orders.

Those doctor people, they're too busy to be explaining much. They tell you what's wrong and what medicine to take but half the time they're so rushed you can barely see their fur fly. . . . Now those nurses, they take the time with you. They tell you what it was the doctor said. What you should do and (laughingly) more what you shouldn't do.

However, physicians were still cited as more important sources of health care information than nurses. The physicians may be viewed as imparting more information than nurses, but less of it may be understood by the patient.

Another source of health information currently employed by this age group is the Bible (30%). Just about every respondent recited Ezekiel 16:6 as a cure for bleeding.

And when I passed by thee, and saw thee polluted in thine own blood, I said unto thee when thou wast in thy blood, live; yea, I said unto thee when thou wast in thy blood, Live.

Though a number of the older women do not read, they are read to by a daughter or granddaughter. When one respondent was asked about her use of the newspaper, she said that she did not read. Later in the interview she asked how to pronounce a name in the Bible. She had been reading the Bible earlier that day and had not known how to pronounce one of the proper names. When I asked about her earlier statement that she couldn't read, she said, "Oh, I only read interesting stuff (the Bible). I don't waste time on the newspaper."

In addition, some of the women have a book on herbs in their homes. A particularly popular title is Back to Eden an herbal compendium that is also found in the homes of many "back to the land"

and counter culture proponents of the 1960's. This reference is used more as a refresher than for acquiring new information.

The media was not reported as a major source of health information although 74% of the older women report watching health related programs on television at least once each week. The most popular programs among this age cohort is the Richard Simmons exercise show and "For Your Information," a series of short health related messages aired in connection with daytime soap operas.

Middle aged cohort (36-59 years of age). Women in the middle aged group reported a similar sequence of health information acquisition. Their chief source of information when they were younger were their mothers, grandmothers, and aunts (60%). They consulted these women for remedies for a variety of common ailments.

As they got older and had children of their own, the women in the middle aged cohort sought advice from their mothers and mothers-in-law. This advice involved treatment for discomforts related to pregnancy as well as remedies for sick babies and younger children. Fewer of these women (10%) mentioned the community midwife as a source of health information probably because most of them had delivered their babies in University Town hospitals rather than at home with the midwife.

Health care professionals, particularly physicians and nurses, are currently this age cohort's chief source of health information. Most of these women see a physician in University Town on a regular basis (at least once every 6 months). Eighty percent report a reliance on them for pertinent information related to specific illness.

Nurses are cited by 52% of the respondents as important sources of health information. A series of outreach nurses from the public health department in University Town visited the community for a time period that closely parallels this age cohort's early adult years. Many of those respondents recalled with fondness the days when "the nurses used to come out to your home, and take your pressure, and see how you were doin'." Ninety percent of this age cohort suggested later in the interview that this practice be revived, thereby demonstrating a reliance on visiting nurses for their health care needs.

A fourth important source of health care information cited by this group derives from television programs. Ninety-four percent of this age group watched television. Ninety-one percent reported that they learned something from television at least one time per week. Exercise programs, particularly the Richards Simmons Show which is viewed by most (93%) women in this age group everyday, are reported to be the most popular type of health related television offering. Sixty-two percent stated that they obtained health information from the newspaper at least once each week. However, this was not cited as a primary source of health knowledge.

Young adult age cohort (20-35 years of age). Eighty-four percent of the young adults cited the physician as the major source of health information. Although 60% of them acknowledge their mothers and grandmothers as important sources of knowledge regarding common illnesses, they consider the doctor the authority who should be consulted "whenever anything goes wrong." This includes taking the baby to the doctor when it has a fever or flu symptoms rather than relying on

remedies suggested by their mothers or grandmothers. This is the age group who frequently uses the emergency room for primary care services. They are the group the community midwife was referring to as "always running off to the doctor."

Young adults (69%) report that television is another major source of health information. They especially like to watch shows that deal with nutrition and exercise. Some even reported getting up to watch a 6 A.M. exercise program before going off to work in the morning.

Books, newspapers, magazines, and pamphlets are a major source of information. Over half of them read about health in the newspaper at least once each week, while three quarters received health information from magazines at least one time per month. This age group also has a number of health books for reference in their homes. Some type of medical encyclopedia or health book appears to be an obligatory item for the majority of women in this age group (81%). One woman reported a recent purchase of this reference with pride and a sense of accomplishment, indicating that she had achieved a certain status by virtue of this acquisition.

Teen age cohort (13-20 years of age). Television was the major source of health information for the teenaged women (69%) followed closely by a health education, physical education, or science education teacher at school (68%). "For Your Information," a short informational segment that is aired in conjunction with the afternoon soap operas, is the primary source of information related to health. Teens also expressed interest in television specials related to "how the body works."

School based health education was the second most often cited source of information related to health. The most popular topics were, again, the functioning of the human body systems and the unit on sex education or human growth and development.

Mothers were cited by 59% of the teens as important sources of health information. However, the teenagers were quick to differentiate their grandmothers' advice from their mothers' wisdom. Seventy percent of the teens indicated that their grandmothers' ideas were "too ole timey and too ole fashioned" to be taken seriously.

Nurses at school and the public health department were named as sources of information primarily related to birth control and care of minor injuries incurred at school. Thirty-nine percent cited nurses as a major source of health care knowledge. It was not surprising that the doctor was not cited as a source of health information since most teenagers in the sample do not regularly see a doctor. However, it was curious that they did not cite magazines as important sources of health information since over half of them (54%) reported reading about health in magazines at least once a month. Articles in monthly magazines about birth control and diets were the topics of most interest to teenagers.

Summary of focused interview findings. To summarize thus far, the data gathered through the focused interview guide support the hypothesis that health care information is transmitted from one generation to another through oral transmission by older women in the community. Usually this woman is a primary caretaker, i.e., mother, grandmother, or aunt, but on some occasions the midwife or other women

in the community known to be knowledgeable about health matters are consulted for advice regarding common ailments and childhood illnesses. As women get older and establish relationships with physicians, they report that they rely more and more on health care professionals for their health information. Nurses as well as physicians are important in this information transfer.

The media as a source of health information is utilized differently by the four age cohorts. Television is reported as increasingly more important as a health information source with decreasing age of the respondent. That is, the teenage cohort relies more heavily on television for information related to health matters; the older age cohort reports the least reliance on this source.

Newspaper articles about health are primarily read by the young adults and middle aged adults, while health topics in magazines are read by young adults and teenagers. However, only the young adults report printed materials, including newspapers, magazines, and books, as major sources of health care information. The radio was not a major source of health information for any of the age cohorts.

Once women establish relationships with physicians, they are likely to rely on them for information about health and illness. However, this does not mean that the information transmitted by doctors is either properly understood or adopted wholeheartedly. Often this knowledge is placed alongside existing knowledge obtained from female relatives during early socialization. When and under what conditions, these coexisting belief systems are called into service will be explored later in this chapter.

Family group information transfer. When comparing the quantitative data gathered on family groups, the findings indicate that the majority of family members are representative of their age cohorts. In other words, women responded in a similar fashion to others in their age group rather than demonstrating particular family patterns. The exception to this tendency was one family group which were members of a strict religious sect. All of these family members cited the church minister as their primary source for health information and the Bible as their next most important source of health care knowledge. This family group, however, was atypical of the general trend toward age group related patterns.

Subsection 2. Data on source of health information gathered through participant observation

When the data collected through participant observation were analyzed according to the coding categories in Figure 6-1, the theme of older women as "socializers," "role models," and "sources of health care information" was repeated over and over again. This theme was both explicitly and implicitly stated.

Several examples from the field notes serve as illustration. A woman in the so called "early retirement years" stated:

My grandmother taught me, when I was coming up, everything you need for fixin' up is right out back . . . and she took me back there in the woods and showed me what was what. . . . I mean she knew a bundle about what would cure ya. Anything you wanted to heal, there was something in the woods for it. . . . Yea, my grannie she learned me good. (Clarice, age 62 years)

A woman in the middle years told a group of community women she was trying to organize into action,

We gots to learn the right way to cook food. High blood and sugar and all sorts of things come from the way we cook. And we gots to do something now 'cuz our young ones are watchin' and learnin' from us. You don't want your babies to grow up and get all these diseases do you? Well, you better learn the right way to do things so you can teach them. They're learnin' bad habits from us and they're goin' to get the same problems we got. Now that don't make no sense does it. I mean, if you can learn the right way (to cook). (Eloise, age 42 years)

Other women present at the time in the same room indicated general agreement on this point by interspersing "that's right," "you know it," "yea, sister," during Eloise's talk.

Additional information elucidated through participant observation reveal several other health information sources. Several women from the research community worked as licensed practical nurses and housekeeping staff in hospitals in University Town. Thus, they were privy to information concerning the health status of hospitalized community members. Daily interpretive reports were offered by these women to family members whose understanding of the disease process and course of treatment often depended more on the informal health source's account than on the physician's or nurse's explanation.

Since these informal health resources shared a common health belief and value system with other members of the community, they were often able to explain the illness or treatment in ways that the family could understand. Furthermore, this access to "inside information" through trusted sources reassured the family that they were getting the "full story" and not a "half truth" from an impersonal health

care professional. The accuracy of these explanations, by biomedical standards, was not always optimal. However, 74% of the community stated that they knew someone who worked in a health care setting and periodically relied on them for information (Table 6-22).

Other women in the community acted as informal referral agents. The lay referral system, illustrated by this research, has been reported extensively in the medical anthropological and sociological literature. (See Review of the Literature, Chapter I.) Though many respondents said they relied on women relatives for this function, some consistently consult one of two or three women in the research community. After discussing and diagnosing the problem, these lay referral agents suggest the "appropriate" health care facility, usually in University Town but occasionally in the local community. Thus, these women are very influential in health resource utilization.

Their own health beliefs, attitudes, and practices affect the health care of those who consulted with them. For example, a person complaining of shortness of breath might be referred to the local clinic if the referral agent felt that the symptom was due to "nerves" and a prescription for a tranquilizer was needed. However, if the referral agent felt that the symptom was due to a "lung problem," then she would refer the patient to a private physician or clinic in University Town. A third possibility might include the recommendation not to seek medical attention at all but rather to reduce the stress induced symptoms through rest and/or prayer. Thus, the diagnosis and referral decision of these informal health experts impacted on the first line treatment plan for many community residents.

Table 6-22. Has close relative or friend who works as:

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Minister	35	37	43	39	23
Doctor	7	0	0	22	0
Dentist	5	5	5	11	0
Healer	7	16	5	0	8
Pharmacist	10	5	10	22	0
Hospital worker	74	74	57	78	92
School teacher	42	37	48	39	62
Counsellor	18	11	9	22	46
Other health care worker	16	11	33	17	15

Subsection 3. Corroboration by data outside the research community

Notes gathered during the Black Women's Health Conference reiterated this theme of older women as transmitters of health care information to the black community in general. Both speakers and participants voiced pride in this shared cultural heritage.

For centuries, we have made a way out of no way. We have cared for our families with herbs gathered from our gardens and with substances collected from our kitchens. . . . Our grandmothers have passed their vast knowledge of these natural and household remedies on to us. . . . So, too, have they passed on their ways of cooking.

Other speakers began their talks with the tacit assumption that everyone participating in the conference knew that women were the chief source of health information for their families and communities.

And so it's your job to influence five people in the next six months to get a check up. Get your family involved. . . . We must accept the responsibility for incorporating healthy behaviors into our lives, and those around us. It's up to us.

A review of popular black literature further corroborated the importance of the female based tradition of health knowledge transmission. An example of this rich tradition follows:

Herbal cures, for many blacks, are an oral heirloom to be had for the listening . . . (My mother) brought Maw's (great grandmother) herbal remedies with her and passed them on to me. Maw's remedies followed the rhythm of the seasons. . . . Roots, leaves, bark, and home-made wisdom. Maw left me a legacy for all seasons. (Garcia-Barrio, 1977, p. 16-17)

Thus, the pattern of health care information in Macedonia-Grove is like that in many other black communities. The older women in the community possess a wealth of health information which they pass on to

succeeding generations. The next section will elaborate on some of these health care practices that are transmitted from one generation to another.

Section B: The Transmission of Health Care Practices

Although the young adult and teenaged women do not cite their mothers or other female relatives as primary sources of health care information, they have actually incorporated many of the older generations' attitudes, values, and practices into their own belief system and behaviors. Numerous examples of home remedies appear in the field notes for such common conditions such as colds, boils, fevers, nosebleeds, and "stomach" problems (Table 6-23). When many of the younger informants were asked if they believed home or herbal remedies to be useful or if they utilized any of them, they scoffed at the mere idea. For example, when I asked one 30 year old woman a question on the focused interview guide which pertained to herbal and home remedies, she replied, "The older people, they believe in all that stuff. But, really, you should see the doctor cuz they got special training in those matters. I don't think you should mess with that stuff."

The "shoulds" in the quotation above represent the ideal for this woman. But the reality of her life indicates a very different practice. Just a month later, this same respondent told me she had had a bad flu the week before. When I asked her what she had done for it, she replied, "I drank some tea Mama made me. It always help to clear your head. It washes out the system." When I asked for specific ingredients, she referred me to her mother. "I never did know what she

Table 6-23. Home remedies for some common health problems

	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
1. <u>Cold</u>				
Molasses tea	X	X		
Pine tops tea	X	X		
Red onion tea	X	X		
Life everlasting tea	X	X		
Sassafras tea	X	X	X	X
Honey, lemon & whiskey tea	X	X	X	X
Eucalyptus oil & honey	X	X	X	X
Kerosene & sugar	X	X	X	X
Rabbit tobacco & molasses	X	X	X	X
Syrup of Black Draught	X	X	X	X
2. <u>Fever</u>				
Warm salt water, drink				
Soda & vinegar, rub chest	X	X	X	X
Poke leaves dipped in cold water, rub	X	X	X	X
Sweet spirits, sniff	X	X	X	X
Bonesett tea, drink	X	X	X	X
Life everlasting tea, drink	X	X	X	X
Pine bud tea, drink	X	X	X	X
Dandelion tea, drink	X	X	X	X
Turpentine, heat, rub			X	X

Table 6-23. Continued

	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
3. Nosebleeds				
Wear key around neck, down back	X	X	X	X
Pack nose with cobwebs	X	X	X	X
Recite biblical verse	X	X	X	X
Pack nose with salt pork	X	X	X	X
4. "Stomach" Problems				
<u>Constipation</u>				
Castor oil	X	X	X	X
Epsom salts	X	X	X	X
Aloe	X	X	X	X
<u>Dysentery/diarrhea</u>				
Burrroot	X	X	X	X
Shoemaker root	X	X	X	X
Blackberry root	X	X	X	X
<u>Upset stomach/indigestion</u>				
Blackberry juice	X	X	X	X
Spirits of ammonia (10 drops in water), sniff	X	X	X	X
5. Boils				
Catnip & sugar, rub	X	X	X	X
Raw egg, rub	X	X	X	X
Meat fat, rub	X	X	X	X
Milky vine, rub	X	X	X	X

puts in it. But she can tell you. She has a tea for just about anything that ails you."

Perhaps this example is a good case in point for the need to utilize both qualitative and quantitative methodologies. Otherwise, one may get an incomplete or skewed picture of the beliefs and practices that exist in the research community. Many women utilize some form of herbal or home remedy. However, when asked directly about this practice, many of the younger respondents apparently felt the need to give the "socially acceptable" answer, at least to a white, health care professional. Even the older women appeared reluctant at first to share herbal remedies. It was only after this researcher indicated a non-judgemental attitude toward such practices that information on this important variable became available.

The practice of herbal medicine has apparently been transmitted from one generation to another through female based oral tradition. However, as one can see from Table 6-23, there is a decreasing reliance on herbal remedies with each succeeding generation. The responses gathered from the older age, middle age, young adult, and teenage cohorts will be reported in sequence.

The older women in Macedonia-Grove 60 years and up truly employ a dual system of health care information and practice. They have a great deal of knowledge of herbal and home remedies which they have gathered from their mothers and other female relatives. Existing alongside this knowledge is that gleaned from physicians and nurses. Practices from both this folk medical system and modern scientific system are part of these women's repertoire. Therefore, herbal and home remedies are used

along with the medications prescribed by the physician, especially by women of this older age group.

More than three quarters of the women in the middle age cohort, aged 36-59 years, still practice the use of herbal and home remedies. Although their repertoire of herbal medicine is not as extensive as the women in the age cohort before them, middle aged women employ a dual system of health information practice. They rely on both home treatments and physician prescriptions. At times, however, they express doubt about the physician's ability to cure certain illnesses.

Bernice, age 47, reports on her recent visit to the doctor.

He says there's nothing wrong with me but I know I have these headaches for some reason. I mean, I never had no headache before that accident and now not a day goes by that I don't have one. Do you thinks that's right? I mean, a person shouldn't be gettin' a hurtin' head everyday. Should they? I think I'm going to find me another doctor-- go to Seaport City or some place. I don't think that one I've been seein' knows nothin'.

Bernice hastened to add that she thought she was going to try aloe juice because her aunt told her that "it's good for whatever ails you."

The young adult cohort, 21-35 years of age, relies on herbal and home remedies much less than the two age cohorts before them. They tend to rely heavily on physician's advice. Nevertheless, some herbal remedies are utilized by this group for specific ailments (Table 6-23).

Only 30% of the teenaged cohort, 13-20 years, reported using home or herbal remedies. These usually took the form of home remedies, i.e., epsom salts as a laxative rather than the herbal remedies practiced by their mothers and grandmothers. They dismissed herbal

medicine as being "ole timey" and seemed to have a very limited knowledge of the contents, preparation or usage of herbal teas.

In summary, the transmission of health care information and practices from one generation to another has been demonstrated through data derived from participant observation, focused interviewing and popular literature review. Though some of these practices have been attenuated over time, many have remained intact. The following section will examine the transmission of some health care beliefs as measured by the internal versus external locus of control.

Section C: The Transmission of Health Beliefs

Subsection 1: Health beliefs as measured by the internal vs external health locus of control scale

It was hypothesized that health care beliefs would reveal a decreasing external locus of control in succeeding generations. Restated, as health care beliefs and values are passed from one generation to another they will become attenuated due to outside influences, i.e., television, printed media, and health information from health care professionals which emphasize the individual's control over his/her health. Thus, it was expected that the youngest age cohort would demonstrate a greater internal locus of control than preceding generations since they presumably had greater exposure to biomedical views through school health education and television programming.

There are many ways of measuring health care beliefs. The instrument chosen to measure health beliefs in this study was the health locus of control scale. Locus of control is a construct derived from Rotter's social learning theory (1954). Two basic personality types

were identified. Those who are internally controlled perceive that events are a result of one's own actions and, therefore, one has control over what happens. Those who are externally controlled view events as beyond one's control and in the hands of powerful others, fate or chance.

Wallston et al. (1976) applied this concept to the health domain and developed a Health Locus of Control scale. Coreil and Marshall (1982) refined the concept to include items which related to both health and illness behavior. The Coreil and Marshall scale was chosen for this research because, as mentioned earlier, the populations it had been validated on shared many characteristics of the research population: rural, lower socioeconomic status, religious, and traditional. Furthermore, the addition of the illness dimension was important since hypertension was used in this research study as a prototypical condition through which health beliefs, values, and practices could be examined.

Total scores have a possible range of 15 to 45 points. The higher the scores on this scale, the greater externality of health locus of control. In other words, the higher the score, the less control the individual feels she/he has over matters related to health and illness. Scores in this sample ranged from 21-38 with a mean of 31.04.

The results of this research confirm the hypothesis. There is a trend toward more internal health locus of control with succeeding generations, as defined by age cohorts (Table 6-24). An analysis of variance revealed a statistically significant difference (at the .05 level) between the older and teen groups. The differences between the middle and young adult groups were not statistically significant and

Table 6-24. Health locus of control scores

All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
31.04	32.73	29.93	31.95	29.53

NOTE: Possible range, 15-45; the greater the number, the more externally controlled.

did not follow the prediction of increasing internal health locus of control. In other words, the middle group had a lower score (more internal) than the younger adult age cohort. This result might be best explained by the presence of two women in the middle aged group who had scores of 21 and 25, 10 and 6 points, respectively, below the mean for the entire sample of 96. Thus, their scores skewed the mean for the middle aged cohort. When the mean was recalculated, eliminating their scores, the midddle aged cohort had a mean of 32.24. When these women are removed from the sample, the trend toward increasing internal locus of control in succeeding generations was confirmed by this study.

When one compares the data by family groups, 18 of 23 families demonstrated this trend toward increasing internality. In four of the remaining five families, the scores of each member were within one to two points, indicating relative stability across generations. In only one family did the member of the third generation have scores that were significantly higher than her mother (10 points) and her grandmother (5 points). This individual variation from the cultural trend underscores the need to individuate clinical applications of cultural data and will be discussed in more detail during the final chapter.

Subsection 2: Role of religion in health belief system

A review of pertinent social science literature (Chapter I) suggests a black religico-medical belief system composed of an intricate blend of health and medical domains. This research effort gathered data regarding the role of religion in the health belief system through both informal and focused interviewing. Spontaneous comments made by the respondents during the administration of the health locus of

control scale explicate the role of religion in the health belief system of the research. Though some expressed the belief that disease is a punishment for wrong doings, most attributed illness to the Devil.

Anna, "God is a loving God. He doesn't punish us. The Devil might put something on us."

Hattie, "The Devil makes you sick. God is too just to make you sick."

Regardless of the cause, the Lord was seen as the ultimate authority in health maintenance and healing by many of the women in this community.

Sadie, "If you believe in Him, you can eat poison and it won't hurt you."

Nellie, "I'm relying on Jesus now. I say, 'you made me, you know me, take care of me.' Honey, I'm in the Lord's hands."

Katie, "What that 'ole man up there has in store for you, that's what you'll get."

Bernice, "When God gets ready for you to get up, you get well."

Most emphasized that the physician is important in healing but secondary to God.

Millie, "If they trust in God, then the doctor can help. They (doctors) can't do nothing without help from God."

Laura, "I let God take care of me. What doctors do, they do with the help of God."

Mary, "God gives doctors the strength to do what he has to do."

An analysis of these beliefs by age cohorts reveals a trend toward increasing reliance on physicians and self for health maintenance and healing. The older women (aged 60+ years) believe that they have little control over what happens to them, that ultimately their lives are in God's hands. The middle aged women (36-59 years) speak more in terms of a God-physician partnership with God working through the doctor to heal.

The young adults and teens expressed a great deal of conflict between their religious beliefs and scientific information gained through the mass media, school, and health care professionals. In response to the question "If the Lord wants to send you an illness, there is nothing you can do to stop it," Sabrina, aged 25 years said, "I know what I should say but . . . this is hard. I mean my religion tells me one thing and yet I know that's not the right answer." When the researcher reassured her that there were no "right" or "wrong" answers, she said, "I know, but there's a real difference between the way my church says (I should believe) and what you hear." In further probing, what she heard was a compilation of biomedical explanations from school, pamphlets, and health professionals. This conflict between religious beliefs and biomedical teachings was reiterated by many other respondents in the younger (13-35 years) age cohorts.

Summary of data on health care beliefs. Thus, although there is an increasing internal locus of control in succeeding generations as demonstrated by the scores on the health locus of control scale, there is a strong religious orientation which conflicts with a belief in the individual's control over his or her fate. These religious beliefs are

reinforced by older members of the family who are highly revered in the community. With the increasing influence of the mass media, conflicting attitudes have been introduced into this rural, isolated, traditional community. The younger members of the community are the ones who appear most affected by these conflicting values since they are most dramatically affected by these outside influences. This differential effect by age and generation emphasizes the importance of an intergenerational examination of data regarding the health belief system of a particular cultural group.

In the next chapter, we will examine the continuities and discontinuities of health information transfer as it applies to hypertension, an important health problem in the black community in general and in Macedonia-Grove in particular.

CHAPTER VII
BELIEFS AND PRACTICES REGARDING HYPERTENSION:
AN EXAMPLE OF HEALTH CARE INFORMATION TRANSFER

Hypertension was chosen as a protean condition through which it would be feasible to focus more specifically on the continuities and discontinuities that exist as health care beliefs, attitudes, and practices are passed from one generation to another. Hypertension is prevalent in the black community in general (28%) (American Heart Association, 1979) and in the community of Macedonia-Grove in particular (42.7%) (Albert et al., 1977). Fifty-two percent of the study sample had been diagnosed as hypertensive (Table 7-1). Of those who were hypertensive, the length of time they had been diagnosed ranged from 1-52 years with a mean of 12.9 years. As would be expected, these figures varied by age cohort (Table 7-2) with the youngest two age groups having significantly less incidence of diagnosed hypertension than the older two age cohorts.

The data regarding hypertension will be reported in two parts: Part I will elucidate the study community's knowledge about hypertension--its numerical definition, etiology, and symptomatology. Part II will focus on the use of this knowledge as exemplified by health practices related to the control, prevention, and treatment of high blood pressure. In each part the research data will be presented first for the study community as a whole. These findings will then be followed by data on family groups and age cohorts.

Table 7-1. Ever diagnosed as hypertensive?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Yes	52	79	62	22	8
No	47	21	38	78	92

Table 7-2. Length of time hypertensive (mean number of years)

All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
12.9	17.6	15.5	5.4	1.0

Part I: Study Community Knowledge
about Hypertension Comparison of
Hypertensives vs Non-hypertensives

It was hypothesized that those who had been diagnosed as hypertensive would have a greater knowledge base regarding this disease than those who do not have the condition. This hypothesis is predicated on the assumption that hypertensive patients would have a greater exposure to information regarding hypertension through increased contact with health care professionals. One might also assume that through the mechanism of selective attention those who had been diagnosed as hypertensive would be more attuned to information in the media vis a vis high blood pressure than those who did not have the disorder.

This hypothesis, however, was not confirmed. Women who had been diagnosed as hypertensive by their physicians (52% of the sample) did not differ significantly in their understanding of the condition, its causality, symptomatology, treatment, or preventability from women who had not been diagnosed as hypertensive. The only variable in which diagnosed hypertensives had statistically significant more information than non-hypertensive respondents was the increased awareness of kidney problems as possible consequences of uncontrolled hypertension (Table 7-3).

There are several explanations for this finding. It is possible that the patient-physician communication is ineffective and thus the hypertensive patient has inadequate information about his or her condition. An alternative explanation is that non-hypertensive women in this sample had more information about high blood pressure than one would expect from a non-affected population. Thirdly, the findings

Table 7-3. Dependent variable: Kidney problems as possible consequences of uncontrolled hypertension

Source of variation:	Hypertension
DF	1
F value	10.15
PR > F	0.0023*

*Significant at the .05 level.

could be explained by a general cultural emphasis on results rather than process. It may be that people are more scared about, and thus more attentive to, the consequences of the disease process than about causality, preventability, and control. A combination of these explanations appears to be the case.

There was confusion and misunderstandings regarding the definition, etiology, symptomatology, control, and preventability of high blood pressure in both the hypertensive and non-hypertensive respondents. Thus, if one presumes that the "patient" group of hypertensives had received some education regarding their disease while under physician care, then one must question the effectiveness of these health education endeavors. The hypertensive group did not differ significantly from the non-hypertensives either in health information, or in health related behaviors, e.g., dietary restrictions, etc. Either advice regarding life style alterations had not been given at all, or it has not been given in a way that brought about the desired behaviors. The next chapter will further explore this aspect of the problem.

Another possible explanation for this finding is related to the distribution of hypertension in the research sample. Over 90% of the women interviewed had at least one family member who had been diagnosed as hypertensive. Thus, almost all of the women in the sample who were not hypertensive themselves had frequent contact with family members who were hypertensive. The explanations of causality and preventability, the treatments employed and the signs and symptoms of this condition as reported by family members diagnosed as hypertensive are all acquired through close family contact.

Younger women who are not hypertensive themselves may have acquired information dispensed by the doctor or nurse directly or may have picked up pamphlets or read posters pertaining to this condition while accompanying a family member to the physician's office. Furthermore, they gain some information through contact with the mass media. Thus, women in this sample who were diagnosed and treated for hypertension did not differ significantly from the non-hypertensive women in their knowledge of this condition. In order to explore whether or not there were other significant variables among the women interviewed vis a vis their knowledge and practices related to hypertension, the data were analyzed by family groups and by age cohorts.

One might infer from its prevalence in the community and its inconclusion in the folk medical domain that hypertension is a condition about which there is much discussion regarding diagnosis, treatment, and prevention. Thus, the structured interview guide contained a series of questions designed to elicit the respondents' beliefs about the definition, causality, symptomatology, treatment, consequences, and preventability of hypertension. The data were analyzed by family groupings, by age cohorts, and by diagnosis of hypertensive vs non-hypertensive.

Study Community Definition of Hypertension

The focused interview guide contained several questions designed to elicit the respondents' definitions of hypertension. Specifically, the subjects were first asked the open ended question, "What does hypertension mean to you?" Twenty-four percent (24%) replied that they did not know what "hypertension" meant, 10% replied that it meant

"hyperactive" (e.g., "You just can't sit still," "jumping around all the time," "all irritable like"), 10% stated that it meant "hypertense" (e.g., "I'm all wound up like a clock--all wound up and don't have a way out), and 12% responded with descriptive rather than definitive explanations (e.g., "It's when your blood 'jumps up', 'comes up', 'draws up' indicating that the condition is one of too much blood in the head). Forty-four percent (44%) correctly identified hypertension as another term for high blood pressure (Table 7-4).

Family group data

An examination of data from family groups indicates that the age cohort to which one belongs is more important than the family affiliation. In other words, members of family groups demonstrated responses similar to the age cohort to which they belonged rather than revealing any striking familial tendencies. However, there were no instances in which the younger members of the family had less understanding of the definition of hypertension than did the older family members. There were some noticeable differences among the age cohorts.

Age cohort data

Older women (aged 60 years and older). Only approximately one-third of the older women, 79% of whom were hypertensive, correctly identified hypertension as meaning high blood pressure.

Instead, they had many more descriptive explanations for the definition of hypertension than did the younger three age cohorts. Hypertension as defined by 32% of the older women is a condition in which the blood gets "too thick" or "too high" and "rushes to

Table 7-4. Definition of hypertension (open ended question)

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
High blood pressure	44	37	52	72	46
Hyperactive	10	0	14	11	15
Hypertension	10	5	10	0	0
Too much blood in head	12	32	14	0	15
Don't know	24	26	8	17	23

the brains." For this group then, the term "high blood," which is sometimes confused with high blood pressure, appears to mean a collection of blood in the head rather than hypertension.

Middle aged adults (36-59 years) and young adults (21-35 years).

Respondents in these two age cohorts had a much clearer understanding that hypertension meant high blood pressure than did the older women. Although only four of the young adults were hypertensive, 18 or 72% correctly defined hypertension on the open ended question. This finding may be explained by their reliance on the electronic and printed media for health information. This group has many health references in their home, reads about health in newspapers and magazines, and receives health messages via television. Thus, even though most have not needed to use the information for their own health care, they do seem to have absorbed it.

Teenaged group (13-20 years). The teen group more accurately defined hypertension than did the older women but demonstrated less understanding than the middle aged and young adults. A possible explanation of this difference rests with their more limited personal exposure to the problem as well as less contact with others with the disorder.

All groups. To the forced choice question, "Does hypertension mean the same thing as high blood pressure," many more respondents correctly identified the two terms as being synonymous. Three quarters of the respondents replied that hypertension meant high blood pressure (Table 7-5). Again there were differences among age cohorts that were

Table 7-5. Does hypertension mean the same thing as high blood pressure? (forced choice question)

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Yes	75	63	81	83	69
No	23	37	19	17	27
Don't know	2	0	0	0	4

consistent with those noted above. The middle aged and young adults had many more correct responses (81% and 83%, respectively) than did the older and teenaged women.

Finally, respondents were told that "another name for hypertension is high blood pressure," and then asked, "What is considered a high blood pressure?" Three quarters (74%) of the respondents reported that they did not know the numerical definition of high blood pressure (Table 7-6). An additional 13% who felt they knew the definition gave a wrong response. Thus, the total number of women who did not correctly identify hypertension as a systolic over 140 mm Hg and a diastolic over 90 mm Hg was 87%. As before, the older age cohort was the least knowledgeable. In the older age cohort, only one respondent knew the definition of high blood pressure to be 140/90 mm Hg. The other respondents said they did not know.

Study Community Beliefs about Etiology of Hypertension

Subjects were asked the open ended question, "What do you think causes high blood pressure?" in order to elucidate further their beliefs about hypertension. The leading causes cited were eating fatty foods (53%), eating too much salt (40%), and "worryation" (27%). A more inclusive "not eating right" or "eating things you got no business eating" (16%) was the fourth most frequent response.

The open ended question was followed by the statement, "Some people think that these things cause high blood pressure. What do you think about high blood pressure being caused by _____." A series of 22 responses were read out one by one and the respondent indicated whether she agreed or disagreed that the particular term

Table 7-6. Numerical parameters of hypertension:

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Correct (> 140/90)	13	5	20	61	15
Did not know	75	95	62	22	77
Incorrect response	13	0	18	17	8

caused high blood pressure. There was also a category for "don't know" (D.K.).

When looking at the responses to the forced choiced questions, the following results are noteworthy. For the variables over which one has some control--alcohol consumption, cigarette smoking, fatty food consumption, salt intake, exercise, weight, hard work, rest, fast life, suppression of feelings, fear, nervousness, and stress--most respondents were in agreement (Table 7-7).

When examining the data on etiology of hypertension by family groups, one notices striking similarities among family members' responses. Of the 23 families represented by the study sample, more than half of them ($N = 13$) demonstrated a continuity of response across three generations. In other words, the causality of hypertension was ascribed to the same agents by mother, daughter, and granddaughter. In six of the 10 remaining families, members of two contiguous generations gave the same answer. In four cases the similar respondents were mother and daughter; in the other two cases the daughter and granddaughter gave the same answer. In most of these families, emphasis was placed on dietary factors and stress level as causative agents. Ascription of causality to forces over which the individual had relatively little control, as mentioned above, was confined primarily to the mothers belonging to the older age cohort and to granddaughters of the teenaged cohort. These findings are congruent with data from the age cohorts.

For the variables over which the individual has relatively little control, there were striking differences among the age cohorts (Table 7-7). The older age cohort believed that hypertension could be caused

Table 7-7. Causes of hypertension ("yes" responses to forced choice questions)

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
<u>Variables individual has control over:</u>					
Alcohol consumption	80	95	90	44	84
Cigarette smoking	47	58	57	28	38
Fatty food consumption (including pork)	97	95	100	94	100
Salt intake	100	100	100	100	100
Exercise--not enough	50	42	48	56	54
Overweight	98	100	95	100	92
Working too hard	66	74	52	56	78
Rest--not enough	64	73	76	33	77
Living fast life	56	68	52	44	46
Suppression of feelings	68	79	76	61	62
Fear	55	84	52	39	54
Nervousness	83	100	81	78	85
Stress/worryation	90	79	90	100	84
<u>Variables individual has relatively little control over:</u>					
Poisons in food	49	74	57	22	38
Evil spirit	16	37	9	5	7
God's will	54	74	38	44	69
Magic	17	42	14	0	8
Punishment	44	74	33	28	62
<u>Variables individual has no control over:</u>					
Age--old	29	42	29	39	31
Genes	70	84	66	83	77
Race--black	25	26	43	22	15

by poisons in food (74%), evil spirits (37%), God's will (74%), magic (42%), and punishment for wrongdoing (74%). This finding is congruent with this age group's higher external health locus of control as reported earlier. The middle two age cohorts, i.e., middle aged adults 36-59 years and young adults 21-35 years, did not believe these variables to be nearly as significant in the etiology of hypertension. Only 38% of the middle aged cohort and 44% of the young adult group believed that God's will was a cause of hypertension. Twenty-eight percent (28%) of the young adults and 33% of the middle adults believed that hypertension could be punishment for wrong doing.

The teen group, however, did feel that God's will (69%) and punishment for wrongdoing (62%) could be causes of hypertension. During the interview process, many of this age cohort reported significant conflict between their religious beliefs and the "right" answer to the interview questions. It appears that the adolescents are still in a period of resolving inconsistencies that exist between the teachings of the church and those of the secular, in this case, scientific world. Thus, it is not surprising that they report the belief in God as a causal agent in hypertension. There were no significant differences among the age cohorts regarding the variables over which the individual has no control whatsoever--"genes," "age," or "race."

To summarize thus far, a comparison among age cohorts regarding beliefs about hypertension reveals some interesting patterns. In the areas over which the individual has some control i.e., diet, stress, exercise, smoking, and alcohol intake, the respondents were in general agreement. A majority believed that these variables could cause high blood pressure. Similarly, in the areas that one has no control over,

i.e., genes, race, and age, the respondents were in general agreement. Genetic makeup was considered an important variable while race and age were not viewed as causal agents in hypertension.

However, for the variable over which the individual has relatively little control, i.e., chemicals in food, evil spirits, magic, God's will, and punishment for wrongdoing, there were differences among age cohorts. The older women, who perceive themselves as having relatively little control over their fate, as measured by the health locus of control scale, not surprisingly ascribe more causality to forces beyond their control than do the younger age cohorts.

It was in the teenage cohort that the results were contrary to prediction. Given their scores on the health locus of control instrument, the teenagers would not be expected to place much emphasis on variables over which they had little control. However, when one considers their developmental stage and the expressed unresolved feelings regarding the role of religion in everyday life, one is better able to understand this finding.

Study Community Beliefs about Signs and Symptoms

Subjects were asked the open ended questions, "How does someone know they have high blood pressure? What are the signs?" Results presented in Table 7-8 reveal that 66% thought that dizziness was a sign while 43% reported that headaches were symptoms of hypertension. "Swimming in the head," which makes one feel drunk, a feeling which was clearly differentiated from dizziness, was reported as a sign by 43% of the respondents and 15% believed that feeling faint was sign of high blood pressure.

Table 7-8. Signs or symptoms of hypertension

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
<u>Open ended questions:</u>					
Dizziness	66	63	71	67	38
Swimming in head	43	37	28	32	8
Headache	43	10	62	17	54
Feeling faint	15	5	0	28	15
Visual disturbances	7	10	0	11	15
Nervousness	6	16	5	11	7
Nosebleeds	4	0	0	0	23
Sweats	7	2	0	0	15
No response	3	0	4	5	4
<u>Forced choice questions: ("yes" responses)</u>					
Sweats	52	37	57	61	85
Nervousness	76	74	90	67	85
Headaches	87	68	95	89	77
Dizzy	98	100	90	100	100
Pounding heart	68	53	71	56	92
Ringing in ears	40	47	57	22	31
Racing pulse	75	63	76	78	100
Nosebleeds	69	68	71	78	69
Emotional outbursts	52	58	43	39	62
Feeling faint	84	74	76	94	100
Visual disturbances	8	21	6	12	7
Swimming in head	47	39	29	37	8

Family membership comparisons revealed little continuity of response across all three generations. In only eight of 23 family groups, members of the three generations described at least one of the same signs and symptoms of high blood pressure. However, respondents from another six families gave similar responses in two contiguous generations, i.e., either mother-daughter or daughter-granddaughter. Thus, there is some transfer of information regarding symptomatology of high blood pressure, but it does not seem to be as striking as transmission in other subject areas.

The only noteworthy differences among age groups are manifested in the teenagers responses. Teens identified nervousness as a prominent sign (23%) whereas the other age cohorts did not even mention this as a symptom. Teens cited dizziness as a sign of high blood pressure much less frequently than did the other three age cohorts (e.g., 38% in the teen group versus 63%, 71%, and 67% in the older, middle, and younger adult groups, respectively). The teenagers responses might be explained by their lack of personal experience with hypertension. They may have interpreted other symptoms as nervousness or attributed general irritability in their elders to their hypertensive condition.

After respondents volunteered their answers to the open-ended questions, the following statement was read to them: "Some people say these are signs. Do you agree or disagree?" A series of 10 symptoms was read one by one to the respondents. As before, "don't know" was an option as well as "agree" and "disagree." Respondents indicated greater agreement with the symptoms that were read to them than they volunteered in response to the open-ended question. No additional findings were revealed, however.

In order to ascertain whether or not subjects believed that those who were asymptomatic could have hypertension, the question was asked, "If you don't feel sick, can you still have high blood pressure?" An overwhelming 91% believed that one can be hypertensive and be asymptomatic (Table 7-9).

Fewer respondents considered a person with high blood pressure sick perhaps because of the widespread incidence of this condition in the community. When asked, "Is a person with high blood pressure 'sick'?" three quarters of the respondents indicated that one should consider a hypertensive sick (Table 7-10). There were no significant findings among age cohorts or family groups.

Part II: Health Practices Related to Hypertension

Study Community Practices for the Control of Hypertension

Subjects were asked the forced choice question, "Can high blood pressure be cured?" Forty-seven percent (47%) replied that hypertension is curable; 50% indicated that high blood pressure could not be cured. Teenagers were more likely (62%) to believe that hypertension is curable than the young adult, middle age and older age groups (39%, 47%, and 42%, respectively). This finding is congruent with teens' higher degree of internality on the health locus of control scale. Teenagers believe that they have more control over their health than do the other age cohorts.

This topic was pursued though the open ended question, "What can help control high blood pressure?" followed by the forced choice item, "Some people think these things can help high blood pressure, do you

Table 7-9. If you don't feel sick, can you still have high blood pressure?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Yes	91	95	76	100	100
No	7	5	19	0	0
Don't know	2	0	5	0	0

Table 7-10. Is a person with high blood pressure sick?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Yes	74	63	71	83	77
No	26	37	29	17	23
Don't know	0	0	0	0	0

agree or disagree?" Results are presented in Tables 7-11 and 7-12. Responses to the open ended question indicated that taking medications prescribed by a physician (63%), eating properly balanced meals (39%), and staying away from pork products, salty foods, and fatty or greasy foods (74%) are all helpful control measures.

There were no significant differences among family groups or age cohorts on the open-ended question. However, on the forced choice questions, there were several interesting differences in responses among family group members. Most of the oldest members of the family groups expressed a heavy reliance on religion and herbal cures for hypertension control. These practices were passed on to their daughters in 17 of the families but only six of the granddaughters knew of home remedies for high blood pressure. Three of these teenagers stated that they had learned about herbal cures from the television program, "For Your Information." In one family group, a strong reliance on prayer and biblical readings was indicated as the treatment of choice for high blood pressure as well as for most health problems.

Thus, there is evidence of discontinuity in the transmission of health practices related to hypertension just as there was in the more general health care domain. Although there is some continuity within individual families, the general trend is one of transmission remaining intact between the first and second generations but becoming attenuated by other forces between the second and third generations.

Age cohort data reveal the same general pattern.

Older Women (Aged 60 Years and Older). Seventy-four percent (74%) of the older age cohort reported knowledge of 15 different herbal

Table 7-11. Control of hypertension: (open-ended questions)

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Staying away from salt, pork, fatty foods	74	59	69	83	62
Taking doctor prescribed medication	63	81	79	61	31
Eating balanced meals	39	36	50	39	22
Losing weight	13	5	23	22	8
Relaxing and/or reducing stress	14	10	28	5	8
Exercise	8	5	4	5	8
No response	4	0	0	0	8

Table 7-12. Control of hypertension: ("yes" responses to forced choice questions)

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Home remedies	53	74	71	17	31
Praying	89	84	90	83	100
Eating certain things	51	47	57	44	38
Staying away from certain things	100	100	100	100	100
Reading Bible	74	84	67	72	54
OTC meds	15	16	14	6	8
Herbs	38	53	38	28	23
Exercise	48	39	43	56	54
Prescribed meds	100	100	100	100	100
Laying on of hands	43	42	67	22	38
Losing weight	97	100	100	94	100
Resting	95	89	90	100	92
Oils/incense	6	5	10	5	0
Wearing objects	5	0	19	0	0
Living Christian life	70	90	88	50	46

or home remedies for the treatment of high blood pressure. The most frequently mentioned were aloe, vinegar, epsom salts, mullein, lemon juice, yellow root tea, and peachtree leaves. Also reported as effective in hypertension control were apple cider, bonesett, life everlasting, cream of tartar, garlic, red root, moss tea, and raw potato in water (Table 7-13).

Middle Aged Cohort (36-59 Years). The middle aged group had a narrower range of herbal and home remedies (eight) but reported almost the same extent of knowledge about them (71%). The most frequently mentioned were epsom salts, vinegar, aloe, garlic, and lemon juice. Also mentioned were apple cider, mullein, and cream of tartar. The use of common household items, e.g., cream of tartar and vinegar rather than herbal remedies, seems to be more salient in this age cohort whereas the older women rely on both herbal and home remedies. It should be emphasized that most advocates of herbal and home remedies use these in conjunction with physician prescribed medication, further demonstrating the coexistence of the folk medical and biomedical domains.

Teenaged Cohort (13-20 Years). The teen group mentioned that they had heard that aloe and garlic were good for the control of high blood pressure. None of this age cohort had had personal experience with herbal and home remedies for hypertension but reports from relatives and the television caused some (31%) to believe that these agents could be effective. Familial data indicate that these remedies are passed intact from the first generation to the second but are often lost between the second and third generation.

Table 7-13. Home remedies for high blood pressure

Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
Aloe	Epsom salts	Vinegar	Aloe
Vinegar	Vinegar	Garlic	Garlic
Epsom salts	Aloe	Epsom salts	Aspirin in water
Mullein	Garlic	Aloe	
Lemon juice	Lemon juice	Lemon juice	
Yellowroot tea	Apple cider		
Peachtree leaves	Mullein		
Apple cider	Cream of tartar		
Bonesett	Lemon juice in coca cola		
Life everlasting			
Cream of tartar			
Garlic			
Red root			
Moss tea			
Raw potato in water			

Another significant difference among age cohorts is the relative importance placed on religion for hypertension control. Although all age cohorts felt that high blood pressure could be controlled through reading the Bible (74%) and prayer (89%), there were marked differences regarding the effect "living a Christian life" has on hypertension. The older and middle aged cohorts believe that living a Christian life (90% and 88%, respectively) could help control high blood pressure. This contrasted with 50% in the young adult and 46% in the teen group. The middle aged cohort showed faith in "the laying on of hands" (67%) as helpful for controlling hypertension but the other three age groups did not express this belief to nearly the same extent.

In summary, the older two groups of women in the sample were more likely to rely on herbal remedies and religious means in conjunction with dietary restrictions, stress reduction and physician prescribed medication for the control of hypertension than were the younger two age cohorts.

Study Community Referral Practices for Hypertension

To the question, "If you thought somebody you knew might have high blood pressure, who would you tell them to see about it?" 93% of the respondents answered unequivocably, "a doctor." Three of the women, all in the same family answered that first the minister should be asked to say prayers for the affected person. A doctor should be seen if the condition persisted. Thus, in this very religious family, a minister was the first line of treatment. This attitude remained intact across all three generations of women.

The frequency with which a person with high blood pressure should see a clinican varied. Forty-seven percent felt that a hypertensive patient should "be checked" monthly, 11% said weekly, and 15% felt that a visit every three months was adequate for checkups. Eleven percent deferred to the doctor, i.e., "whatever the doctor says."

No familial group trends were noted. The only significant difference among age groups was the frequency with which teens relied on physician instructions regarding scheduled appointments (i.e., 23% as compared to 11% reported by the group at large).

In summary, despite a history of self care and the current practice of herbal and home remedy, the physician is still viewed as the authority who should be consulted if hypertension is suspected. This finding, of course, does not preclude the practice of self treatment, but rather indicates the dual system of health care utilized by the research sample.

Study Community Beliefs about Consequences of Uncontrolled Hypertension

Subjects were asked the question, "What can happen if a person has high blood pressure and they do not take care of it? Do you think they would get _____." A list of 10 possible consequences of uncontrolled hypertension was read to each respondent who was instructed to indicate whether she agreed or disagreed with the possible complications.

The consequences of uncontrolled hypertension were in order of most frequent response: stroke (98%), rundown feeling (93%), heart attack (91%), early death (83%), hardening of arteries (73%), paralyzed

(68%), other heart problems (91%), kidney problems (53%), and diminished sexual desire ("lose one's nature) 40% (Table 7-14).

Everyone indicated that there would be some consequence if hypertension was not treated. Data from family groups corroborate age cohort findings. The only noteworthy difference among the age cohorts on this item was in the category of diminished sexual desire ("lose one's nature"). Sixty-nine percent of the oldest age groups felt that this was a common consequence of uncontrolled hypertension while approximately one third of the younger three age cohorts reported "that they did not know" if that was a consequence and another one third did not feel that this was a problem. Many of the younger women laughed and made comments at this question, i.e., "I sure hope not," "Oh no, that's worse than dying."

Whether or not this difference in age related response can be explained by experimental variations is unclear. Throughout the questionnaire women tended to respond in terms of their own experience, (i.e., "No, I've never had nosebleeds, so no I don't think that can be a symptom"). Seventy-nine percent of the older age cohort have been diagnosed as hypertensive. It is difficult to know whether they are experiencing diminished sexual desire and are attributing this to hypertension (when in fact it is a side effect of the medication they are taking or related to some other problem). However, this belief seems to be widespread in the older age group (from clinical experience, older men in the community also believe this), but does not appear to have been transmitted to succeeding generations.

In order to ascertain whether subjects felt that these consequences were inevitable, the forced choiced question, "Can these

Table 7-14. Consequences of hypertension: ("yes" responses to forced choice questions)

	All Respondents %	Old Adults (60+) %	Middle Adults (36-59) %	Young Adults (21-35) %	Teen (13-20) %
Stroke	98	100	100	100	92
Heart attack	91	100	90	83	85
Other heart problems	57	58	62	56	69
Kidney	53	47	71	33	54
Rundown	93	95	90	94	100
Lose nature	40	68	33	28	31
Die early	83	84	81	89	85
Hardening of arteries	73	84	90	56	61
Paralyzed	68	89	76	61	46
Nothing	0	0	0	0	0

things happen even if a person takes care of their high blood pressure?" Three quarters of the respondents answered "yes" to this question (Table 7-15). The middle age cohort expressed a bit more optimism than the other three age cohorts. Forty-three percent (43%) of this age group indicated that these consequences could be avoided if a person with hypertension took care of her/himself.

Study Community's Beliefs and Practices Related to Prevention of Hypertension

An indirect indicator of the control one believes she or he has over health matters lies in the area of prevention. Women in the study sample were asked the close ended question, "Can we keep people from getting high blood pressure?" Approximately one half of the respondents believe that hypertension can be prevented (Table 7-16). Interestingly, there were no differences among the age groups in the frequency of this belief. One might expect that the older age groups with a greater external locus of control would not subscribe to the belief that this disorder could be prevented. However, the older two age cohorts had, if anything, a higher percentage of members who believe in prevention of high blood pressure than did the younger group.

Of those who felt hypertension could be prevented, stress reduction, dietary modifications (i.e., limiting salt, eating low fat foods) getting rest, staying calm, losing weight, and praying were named as critical behaviors (Table 7-17).

Only five of the 23 family groups demonstrated a consistent pattern of attitudes toward prevention vis a vis hypertension across

Table 7-15. Can these things happen even if one does take care of oneself?

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Yes	74	74	57	78	77
No	26	26	43	22	23

Table 7-16. Prevention of hypertension:

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Can prevent	46	53	57	39	46
Can't prevent	48	42	43	56	34
Don't know	6	5	0	5	0

Table 7-17. Of those who felt hypertension could be prevented, means to do so: ("yes" responses to forced choice questions)

	All Respondents	Old Adults (60+)	Middle Adults (36-59)	Young Adults (21-35)	Teen (13-20)
	%	%	%	%	%
Stay calm	86	75	92	88	100
Limit salt	96	100	100	100	100
Low fat foods	96	100	92	100	100
Lose weight	96	92	100	100	100
Drink beer	< 1	0	0	13	0
No cigarettes	66	42	75	63	84
Stay busy	26	25	25	38	17
Church	34	42	17	50	52
Get rest	92	92	92	88	100
Eat certain things	32	25	42	63	13
Reduce tension	90	75	92	100	100
Praying	82	75	92	75	83

three generations. Thus, this belief does not seem to be transmitted through the female based oral tradition. Perhaps health education has the greatest potential impact in the area of prevention.

No age related differences were identified except that 63% of the young adult age cohort (21-36 years of age) stated that one could prevent hypertension by eating certain things--primarily garlic and aloe. Only 25% of the older women, 42% of the middle aged group, and 13% of the teenagers expressed this belief. It is interesting to note that although the young adults do not frequently utilize herbal and home remedies for control of hypertension, they do subscribe to these practices for prevention. These findings or prevention have clinical significance which will be discussed in the next chapter.

Health care behaviors do not always match health care beliefs. Only 27% of those who have not already been diagnosed as hypertensive reported taking preventative measures. The preventative health behaviors were primarily a combination of salt limitation and weight reduction. There were no familial patterns noted. Findings were consistent across age cohorts except that only one of the teen cohort was participating in preventive measures related to hypertension.

Concluding Summary

Responses to a structured interview guide indicate a continuity of many health care beliefs and practices related to hypertension across three generations of women. Members of certain family groups gave amazingly similar responses to the interview questions. In these families, beliefs and practices related to hypertension appear to have been transmitted intact. There are few differences in the members'

beliefs about the etiology, control, preventability, and consequences of hypertension.

However, discontinuities between generations existed in two domains. In the realm of health care beliefs, generational differences occurred in the degree to which individuals felt that forces over which they had relatively little control influenced their health. Older women, ascribed more power to God, evil spirits, magic, and chemical contamination in the etiology of hypertension than did younger generations.

In the domain of health care practices, there were generational differences in the use of herbal and home remedies. Though the knowledge of these treatments has passed from the older generation to the middle aged one, many of these practices are being lost on the younger generations who consider them "old timey" and out moded.

These findings are consistent with the hypothesis that there will be less reliance on health care information transmitted through older female relatives when there is greater exposure to biomedical beliefs and practices. The younger women of the research community have greater access to belief systems that are different from those in their community through school, employment, and mass media. Thus, it is not surprising that these women have rejected health care practices that are not validated by the "scientific" community, i.e., herbal remedies and opted for more socially acceptable behaviors, i.e., reliance on the physician. The implications of these findings and those from previous sections will be discussed in the next chapter.

CHAPTER VIII DISCUSSION OF RESEARCH FINDINGS

The purpose of the following discussion is to highlight the results and problems addressed in the area of acquisition and transmission of health beliefs and practices. It is important to place the data from the study community in a larger sociocultural context and examine the significance of the research findings in relation to other studies. This approach allows for cross cultural comparisons and generalizability of the data to other communities and health conditions. This chapter will conclude with recommendations for further research.

Relevant research in the social sciences should exhibit a blending of concern about current public issues with methodologically sound information gathering and theory testing procedures. (Pelto, 1970, p. 325)

This research used both quantitative and qualitative methodologies to determine intergenerational continuities and discontinuities in health information, beliefs, and practices in a rural black community. Complementary evidence was gathered through a variety of research strategies to provide a reconciliation of seemingly adversarial evidence and interpretation. Hypertension was chosen as a focus for this inquiry not only because it is a major chronic health problem in the black community, but also because it is one that is affected by lifestyle behaviors. It is contended that an understanding of a

community's health beliefs and practices will facilitate the development of more culturally relevant health education and treatment intervention. Thus, the purpose of this research effort was the elicitation of data that would have direct clinical application.

A discussion of specific clinical applications of the data will be postponed until the next chapter.

The Sociocultural Context

This study demonstrates Kleinman's (1980) findings, i.e., that a health care system integrates the health related components of a particular society. As such, it includes peoples' health beliefs and patterns of behavior both of which are governed by cultural rules and influenced by social institutions, i.e., clinics, hospitals; social roles, i.e., sick, healing; interpersonal relationships, i.e., physician-patient, family-patient, social network; interactional settings, i.e., home, office; economics and political constraints, i.e., cost of care, availability of care; available treatment intervention; and the type of health problem. Patients and healers are basic components of this system and as such are embedded in "specific configurations of cultural meanings and social relationships" (Kleinman, 1980, p. 26).

This study has been an examination on a microlevel of the interpersonal sphere of the health care system. It has explored the socialization process by which individuals internalize the cultural norms related to health beliefs and behaviors in a rural black community in the American South. This enculturation takes place initially within the sphere of the extended family. Female relatives

as well as other older women in the community transmit the culturally agreed upon health care beliefs and practices through oral explanations and modelling behaviors to members of succeeding generations. This evidence is congruent with the findings described by other researchers (Snow, 1976; Dougherty, 1976; Bullough and Bullough, 1972; Hill, 1976; and others).

However, this research effort provides additional data that further illuminates the health information transfer process. The research community was not viewed as a single entity but instead examined by age cohort and family group membership. When the data is analyzed, using this research strategy, it reveals important differences within the same community.

The influence of older women as transmitters of health information becomes attenuated by increasing exposure to the beliefs and practices of the world outside the community through the media, education, employment, and contacts with the health care system. These attenuating influences were differentially experienced by the four age cohorts that were studied. The younger respondents ascribe less significance to the female based oral tradition of health information transmission than do the older women in the community. Furthermore, some family groups demonstrated unique patterns of health care beliefs and practices while others displayed age specific rather than kin identified health care patterns.

To summarize thus far, this research found that although older women in the community were still important sources of health care information, there are other, often competing influences. The weight afforded a wide range of health information sources varies with age of

respondents and with family group membership. Some families demonstrated clear patterns of continuous health beliefs and practices across generations. Other families did not follow this trend. Members of these family groups reported beliefs and practices that were congruent with others in their age cohort but were discontinuous with those of their female relatives. In these cases, it was evident that the media, contact with the health care system, or other health information sources, were more significant than the teachings of older women in the family.

These research findings underscore the necessity of determining the health belief system at both the community and individual level. There are certainly many shared beliefs among the members of a community. The more isolated the community is from outside influences, the more homogenous the belief system will be. However, as individuals have increasingly more contact with beliefs from outside the community, competing influences will be introduced. At this point, one would expect a more heterogenous set of beliefs and behaviors.

Indeed, this research indicates that the younger members of the community have more contact with biomedical views regarding health and illness through school, employment, and the media. Thus, it is not surprising that their health attitudes and practices are more congruent with those of mainstream American medicine. Data derived from the health locus of control instrument serve as one illustration of this trend.

Although the research sample as a whole had high scores (indicating an external health locus of control), the four age cohorts demonstrated significant differences. With decreasing age, there was

increasing internality. Restated, younger women believe that they have more control over health matters than do older women. Thus, there is a trend toward health beliefs more congruent with the biomedical view of health care. This finding has significant implications for clinical care which will be discussed in the next chapter.

Older women from the research community manifest a more fatalistic view of the world in general and of health in particular. These beliefs are congruent with those described in the social science literature for rural, lower income, and socially isolated groups. Coreil and Marshall (1982) found a similar fatalistic world view among Haitian blacks and rural Appalachian whites. The cross cultural similarities suggest that other cultural groups which share this sociodemographic makeup will demonstrate comparable belief systems. However, it is difficult to compare the aforementioned data set with the findings from this study since Coreil and Marshall did not distinguish their respondents by age and family groups.

Likewise, dissimilar research strategies pose a dilemma when attempting to place the data regarding hypertension in a large socio-cultural context. Most of the previous research efforts in the area of hypertension have viewed all blacks as a single cultural entity. Certainly none have differentiated age cohorts or family groups for comparison of health beliefs and practices.

Results obtained through this research effort suggest the inadequacy of this singular approach. There are age related and familial patterns in beliefs and practices related to hypertension. Although there are many continuities across age cohorts and family groups, there are some significant discontinuities. The two primary

spheres where these occur are in the area of health practices related to hypertension control and in the domain of health beliefs concerned with etiology.

The dual system of folk and biomedical health practice has been described by many anthropologists cited in Chapter I. However, few of these researchers have focused on this duality vis a vis a particular health condition. Only one investigator, Tripp-Reimer (1983), examined the generational differences in health practices among respondents. This doctoral research corroborates Tripp-Reimer's findings that traditional or folk practices become attenuated over time. Succeeding generations reported less knowledge and more limited usage of folk cures than did their predecessors. Existing alongside this folk healing tradition is the biomedical system of care. Patients in this study reported heavy reliance on prescription medications for hypertension control while at the same time utilizing herbal and home remedies.

Although biomedical practitioners often express dismay over this folk practice, they have devoted little research time and effort to determining the efficacy or harm of specific home remedies. Of those remedies mentioned for high blood pressure, only garlic has received attention in the medical literature. Thus, practitioners should exercise some caution in blanketly denouncing all traditional health practices until they can determine which ones are harmful, which are neutral, and which are even beneficial. This approach will be discussed further in the next chapter. However, it needs to be re-emphasized at this point, that patients are not substituting herbal and home remedies for biomedically prescribed treatment regimes.

Instead, there is a complementarity of practice between the folk and biomedical approaches.

There are striking discontinuities among generations in the domain of health beliefs as well as in the area of health practice. These differences are primarily related to the ascription of causality in hypertension. Older women believe that variables over which one has little control, i.e., magic, evil eye, punishment from God, etc., are significant in etiology of high blood pressure. Younger women ascribe causality to variables over which the individual has control, i.e., diet, stress, pace, etc. These differences among age groups were related to the degree over which individuals believe they have control over their lives, as measured by the health locus of control scale.

Many researchers have characterized those who are poor, rural, uneducated, and members of ethnic minorities, as fatalistic regarding health and illness matters. The blending of the religious and medical domains have been described for a variety of cultural groups but none have examined the intercultural discontinuities. Data from this research effort point to age related differences in health beliefs. Thus, health belief systems of cultural groups should not be viewed as static but subject to mediation by a variety of variables which differentially impact on age cohorts and familial groups. This finding has clinical significance in the treatment and education of hypertensive patients which will be discussed in the next chapter.

Limitations of the Study

There are two limitations of this research strategy which should be noted. The first concern relates to the question of the

maturity effect. It is not clear from this research approach whether or nor the younger women in the research community will rely more heavily on home and herbal remedies as they get older. Likewise, it is difficult to predict whether or not the strength of religious conviction will increase with age. Restated, it is unknown whether religiosity is characteristic of a developmental stage or an ongoing world view. Certainly, a longitudinal study, by age cohort, would answer these questions more effectively.

The second limitation of this research endeavor relates to the particular health condition which was the focus of inquiry. The age cohorts were differentially affected by this problem. Since the younger women in the sample had a very low incidence of diagnosed hypertension, they reported many fewer health practices related to high blood pressure control. Therefore, it is difficult to know how they will act if and when they are faced with the problem themselves. A comparison of health beliefs and practices related to a condition or problem equally shared by the respondents would eliminate this problem.

Generalizability of the Data

Since the research site was chosen for its representativeness, it is anticipated that findings from the study can be generalized to other rural black communities. The similarities in health beliefs between this sample and other rural communities, both white and black, indicate that the results from this research effort can be applied to other rural communities as well.

A survey of medical anthropological and sociological literature indicates that many of the health care dynamics vis a vis hypertension

described in this study are comparable to those regarding other chronic conditions (McKinlay, 1973; Suchman, 1965; Hill 1973; Hill and Matthews, 1981). Thus, the findings of this research are applicable to clinical care and health education in a variety of settings and dealing with a broad range of health issues. However, this study suggests a number of research questions that merit further investigation.

Recommendations for Further Study

1. What is the role of functional illiteracy in the health information transfer process?
2. What role do religious beliefs play in the utilization of health care resources?
3. What amount of information transmitted by health care professionals is actually understood by patients?
4. What are the significant contributions to health information transfer in other ethnic groups?
5. Are acute illnesses subject to the same or different health information influences as chronic illness?
6. Under what conditions is false health information transmitted intact? What causes misinformation to be corrected?
7. How do lay referral agents influence health care utilization for a variety of specific illness categories?

In summary, when placing the data from this research in a larger sociocultural context, one gains an appreciation for the generalizability of the findings to other communities and other health problems. The next chapter will elucidate specific clinical application of the data generated through this research effort.

CHAPTER IX CLINICAL APPLICATION OF RESEARCH FINDINGS

Apart from raising further research issues, this type of investigation stimulates practical applications of the research findings. The implications for both community health education and the clinical encounter are discussed in this chapter. Part I will discuss the important contributions of the media, the black church, the school system, and older women in the community in health education efforts. This will be followed by Part II which suggests prescriptions for restructuring the clinical encounter in order to devise treatment plans that are culturally relevant. It is contended that these therapeutic approaches will be more efficacious than those which ignore the significant contributions of cultural information.

Statement of the Problem: Patient Non-compliance

The importance of conducting this type of research is dramatically illustrated by a poem written by Gerald Dees, a black New York physician, and distributed by USV laboratories as a patient education hand-out. This work underscores a major concern in clinical practice--the problem of patient non-compliance with medically prescribed regimes.

Hattie Brown

Hattie Brown died last night
No one really knows why
Mother of seven children
You could never hear her cry
(Hattie was told she had high blood pressure.)

Hattie Brown was found last night
Lying on the kitchen floor
Dollar bill in her hand
She was going to the store
(Hattie was given medicine for her high blood pressure.)

Hattie Brown was laughing
In the early afternoon
She had been mother and father to her children
Couldn't find her man
(Hattie took her medicine only when she had a headache
or felt dizzy.)

Hattie Brown promised last Christmas
If God would let her live
She would buy the biggest tree
And more than tears would give
(Hattie's blood pressure remained uncontrolled.)

Hattie Brown was a beautiful woman
I can't give you the reason why
She lived with only hopes and promises
The question is DID SHE HAVE TO DIE?
(Hattie had a stroke.)

Social science and medical literature is replete with examples of (1) patients who failed to take their medications regularly, (2) of those who discontinued the prescribed treatment before therapeutic levels were reached, and (3) of clients who failed to alter other life threatening or disease producing behaviors. There is no doubt that non-compliance is a problem. Psychological, economic, religious, and sociocultural factors create barriers that influence the patient's ability to comply with prescribed treatments.

It is the contention of this researcher that patient compliance would be greatly improved if health education and medical practice were

redesigned to deliver culturally appropriate health care. Specifically, it is argued that the findings from this research endeavor can be applied to redesign community and individual patient education as well as to restructure the clinical encounter. An exploration of this multifaceted approach will be elucidated in the following sections.

Part I: Community Health Education

Many health issues are a community wide concern: they impact on many more people than those who have been identified as "patients" by virtue of a specific disease diagnosis. Findings from this research effort indicated that 90% of the respondents had at least one family member who had been diagnosed as hypertensive. Thus, high blood pressure is a community health concern in Macedonia-Grove as well as in other black communities in the United States.

Since a large percentage of the community is involved with hypertension in some way--either as a patient or a caretaker--education regarding high blood pressure should have a community based thrust. Community health education efforts should utilize existing community institutions as a vehicle for imparting health messages. Given the research findings from this study, the family, particularly the older female members, and the church are two key resources in the black community. These resources as well as the mass media and the school system should be utilized to aid in health information transfer.

Older Black Women as Health Educators

Although their influence has been attenuated to some extent by a variety of means, i.e., mass media, contact with the health care system, older black women still play an important role in the transmission of health care attitudes, beliefs, and practices to upcoming generations. Especially in communities where the older women continue to assume responsibility for meal planning preparation, for childcare (in sickness as well as in health) and for leadership in the community and church, their importance can not be undervalued. Educational efforts aimed at impacting on their health beliefs and practices will thus have important ramifications for succeeding generations.

This informal role as folk medical adviser and socializer of succeeding generations could be formalized, and training programs through church groups, sewing circles, or other existing community groups could be provided. In this manner, accurate health information and healthful practices could be introduced into the community.

A community based cooking class is one opportunity for older black women to serve as educators in their communities. For example, one of the problems related to hypertension control in the black community is the heavy reliance on salt and fat for seasoning during food preparation. Most women learn cooking techniques from their mothers and/or grandmothers. Thus, attempts to alter these unhealthy cooking techniques might best be accomplished by first teaching women in the older generations strategies for seasoning using alternative means, i.e., herbs, spices, lemon juice, garlic, etc. These older women could then teach the younger generation more healthful ways to prepare

traditional dishes through individual example and group cooking classes.

Similarly, older women could serve as role models and potential change agents in a variety of other areas that impact on health. It is suggested that these local health experts be incorporated into community based weight reduction, smoking cessation, and stress reduction groups, cooking, parenting and exercise classes, health screenings, and other local efforts to improve the health of the population. In this manner, their power and influence could be utilized to maximize community health efforts.

The Role of the Black Church in Community Health Education

Many women in the research sample indicated a conflict between their religious beliefs and biomedical advice and beliefs. Thus, it seems important to involve black churches in community health education efforts. Health workshops for black ministers could educate them while at the same time enlisting their aid in helping community members resolve religico-medical conflicts.

The church hall, which is a popular gathering place for many community residents, can be utilized for health screenings, workshops, and programs. Through this mechanism, the church can legitimize and sanction health related endeavors. The mutual aid system already existent among church members in the black community could be utilized to spread health messages and change health behaviors.

The Role of Mass Media in Community Health Education

Data from this research effort indicate that the mass media, particularly television, can be an important source of health information for rural black women. The effectiveness of this medium, however, differs by age of the viewing audience.

Television as a means of imparting health information is most effective in the two younger age groups, 13-20 and 21-35 years. Health messages targeted for these groups should be aired at times when young women normally watch television--primarily late in the afternoon and early evening. The content of these messages should be culturally relevant and age specific. The use of significant others in the cultural network to illustrate some aspect of health care would be most effective. The format for these messages can be special interviews, talk shows, public service announcements, special documentaries, or short informational inserts, e.g., "For Your Information." The health message can also be incorporated into the story line of existing shows, such as soap operas or medical dramas, i.e., "General Hospital" or "St. Elsewhere," that are typically watched by the intended audience.

Alcalay (1983) who examined the impact of television on health information acquisition and behavior change, notes that two conditions increase the effectiveness of this medium: the television message needs to provide concrete steps toward achieving behavior change and the message must be reinforced and individuated by a health professional. Thus, community health education efforts must accompany media efforts for optimal impact. As was stated earlier, age cohorts will respond differentially to health care professionals.

Media messages for teenagers should optimally be reinforced by their health teachers or school nurse since these professionals were cited as important health information sources for this age group. In the young adult group (aged 21-35 years) the media message would be best reinforced by the personal physician or nurse. This educational role necessitates that health care providers become familiar with health messages voiced by the media. In this way, these knowledgeable professionals can correct misinformation and reinforce accurate concepts and recommendations. This idea will be elaborated in the section pertaining to the clinical encounter.

It is unlikely that the middle aged and older women (36 years and over) would be significantly reached by a media effort since these two age cohorts did not perceive the mass media to be an important source of health information. These women will be more effectively reached through community groups (i.e., sewing circles, church gatherings, senior citizens programs) as mentioned earlier.

The second necessary component for effective media information transfer, as illuminated by Alcalay, is the provision of concrete steps toward achieving behavior change. Therefore, media messages should not only impart health information but they should delineate ways to accomplish life style alteration. For example, in the case of hypertension control, the mass media message should not only state that sodium limitation is helpful but also suggest ways that the viewer can accomplish the dietary restriction, i.e., demonstration of ways to cook with herbs and spices as substitutes for salt. Suggestions for ways to limit usage of processed foods that are high in sodium,

etc., by replacing them with inexpensive, easy to fix healthy foods would also be helpful. Utilizing significant members of the black community, i.e., local leaders or national celebrities would add credibility and reinforce the importance of the health issue. Again, these efforts should be pitched toward the younger audience who reportedly relies on the media for health information.

To summarize, then, television can be an effective means of providing health information and effecting health related behavior changes if two additional conditions are met. The message needs to provide concrete steps toward achieving behavior change and the message must be reinforced and individuated by a health professional. Alcalay (1983) indicated that messages that take account of the sociocultural, environmental, and economic elements surrounding the targeted groups will be most effective in creating long lasting behavior changes. Therefore, age specific media messages which give specific suggestions for behavior change and are reinforced differentially for the younger two age cohorts would seem to be the most efficacious.

The Role of the School in Community Health Education

The schools are an excellent forum for education related to health matters. Indeed, the teenagers interviewed in this research effort reported that their school health teacher was an important source of health information. An excellent example of this concept in practice is the Technical Assistance Health Resource Group (TAHRG) Community-in-the-Classroom Model. In this model program, health care professionals from the community act as co-instructors with science teachers from the

school system to provide clinical application of basic science principles.

By incorporating culturally relevant information into school health education efforts, students would learn specific ways to alter disease producing and life threatening behaviors. For example, the home economics teacher could provide students with techniques to accomplish the sound nutritional goals that the science teacher encouraged for disease prevention. The physical education teacher could work with the home economics and science teachers to provide a comprehensive plan for sensible weight control. Through a concerted schoolwide effort, teenagers could be taught not only health principles but also concrete ways to attain these goals. The schools as providers of health information have tremendous potential.

In summary, community health education should be culturally relevant and age specific. Research findings indicate that various age groups differentially utilize the variety of health information sources. The reliance on a particular information source is not static but changes over time and is dependent on one's age and degree of contact with the health care system, school system, and mass media. All of these variables must be considered when designing effective community education intervention. Specific suggestions were made for reaching each age group, using information regarding hypertension as a focus. The next section will describe the clinical encounter, another important forum for health information transfer.

Part II: Restructuring the Clinical Encounter

The clinical encounter affords the unique opportunity for patients and health care professionals to exchange ideas and views regarding health and illness. Indeed, women in this research sample indicate that health care professionals, particularly physicians and nurses, are important sources of health information in their adult years. However, too often a one-way transmission of information rather than a two-way exchange takes place. In order for the clinical encounter to be efficacious, it must be restructured to include the following: a means for eliciting the patients belief system, a method for incorporating culturally relevant variables into the treatment plan, an attempt to invite the patient to become a therapeutic ally, and a mechanism for enlisting the aid of significant others in the patients' network. These possible courses of action are suggested based on the research findings. Of course, evaluative research is needed to assess the efficacy of these approaches.

Eliciting the Patient's Belief System

Knowledge of the patient's belief system is essential for the development of a culturally appropriate treatment plan. In order for the health care practitioner to gain a better understanding of the patient's belief system, the usual history and physical must be modified to include elicitation of culturally significant information. The following interview guide can be implemented by physicians, nurses, physicians' assistants, and other clinicians.

Harwood (1981, p. 486) suggests the following approach as a way of eliciting the patients concept of illness in a way that is non-judgemental and communicates a genuine interest in the response.

I know that patients and doctors (nurses/physician assistants) sometimes have different ideas about diseases and what causes them. So it's often important in treating a disease to get clear on how both the doctor and the patient think about it. That's why I'd like to know more about your ideas on (whatever disease or symptoms is relevant to the situation). That way I can know what your concerns are, and we can work together in treating your sickness.

This introduction can then be followed by a series of questions designed to elicit the patients' health beliefs and practices (modified and expanded version of earlier series designed by Kleinman et al., 1978).

1. What do you think caused your problem?
Why do you think it started when it did?
2. What do you think your sickness does to your body?
How does it work?
3. How severe is your sickness? How long do you think it will last?
4. What are the main problems your sickness has caused for you?
5. Do you know anyone else who had this problem? What did they do to treat it?
6. Did you discuss your problem with any of your relatives or friends? What did they say?

7. What kinds of home remedies, medicines, or other treatments have you tried for your sickness? Quantity/Dosage? Frequency? How prepared? Did it help? Are you still using it/them?
8. What type of treatment do you think you should receive from me? What are the most important results you hope to receive from this treatment?
9. Do you think there is any way to prevent this problem in the future? How?
10. Is there any other information that would be helpful for designing a workable treatment plan?

This clinical strategy should provide important data on the personal, familial, and cultural factors that impact on the patient's belief system. This multifaceted consideration is important since findings from this research endeavor indicate that although there are certainly many commonalities in health beliefs and practices of a particular cultural group, there are differences among family groups and age cohorts. Thus, it is necessary to elicit the individual patient's belief system in order to avoid stereotypical assumptions and misconceptions.

Furthermore, this data elicitation technique is both time and cost effective. How much simpler to ask the patient a few questions which will facilitate the development of a culturally appropriate treatment plan than to disregard this information as being irrelevant, and thus devise a treatment regime which will not be followed because it conflicts with the patient's belief system.

Inviting the Patient as a Therapeutic Ally

After eliciting the patient's belief system, the clinician should clearly and thoroughly explain his/her own view of the patient's problem in non-jargonistic terms. In this manner, any conflicts between the patient's belief system or that of the practitioner are revealed and open for discussion.

Harwood (1981) outlines three general methods of handling these conflicts. In the patient education approach, which is in current widespread usage, the knowledge and authority of the biomedical practitioner are employed to change the perceptions and behaviors of the patient. This assumes that the patient is an empty vessel into which scientific truths are poured. Clearly, the research findings indicate that this is not the case.

The second approach attempts to work completely within the patient's conceptual system. A treatment plan is implemented which the clinician considers effective and which does not violate the patient's conceptual framework. This approach, while certainly more culturally sensitive than the first appears unrealistic and impractical for wide-spread adaptation. In reality, there are likely to be real differences between the patient's and physician's belief systems which are expressed both in terms of cognitive content and therapeutic expectations and goals.

In the third approach, negotiating compromise, the patient and clinician agree to a treatment plan that accommodates each person's view point but does not require either of them to accept the other's conceptual model. Kleinman et al. (1978, p. 257) states that this

negotiation process with the patient as a therapeutic ally may be "the single most important step in engaging the patient's trust . . . promoting compliance, and reducing patient dissatisfaction." This approach acknowledges the importance of the patients experience and his or her interpretation of the illness episode. Furthermore, since the practitioner and patient devise a treatment plan together, the patient can signal which behaviors are easily achieved and which ones are more difficult to institute. This approach improves upon the existent one in which patients are encouraged to passively accept the practitioner's orders.

Incorporating Culturally Relevant Information into the Treatment Plan

Once the practitioner has elicited the patient's belief system and enlisted his or her aid as a therapeutic ally, it is possible to devise a treatment plan that incorporates culturally relevant information into the treatment plan. Some examples from this research will illustrate this point.

Utilizing Information from the Health Locus of Control Test

The first example refers to the degree to which patients perceive they have control over their own health. Answers to the health locus of control questions indicate that members of the research community are externally controlled. Restated, these rural black women believe that they have little control over what happens to them. Their firm religious beliefs coupled with their life experiences as socio-economically oppressed members of society engender a reliance on God

as the ultimate, responsible authority. This external locus of control has implications for the therapeutic treatment plan.

Patients who believe that "what will be, will be" and "when people get sick it is up to God whether or not they get well" will be less amenable to adopting preventative health behaviors or following long term treatment regimes than patients who feel that the individual has control over his or her health. However, several other research findings should be considered.

First, there is a trend toward increasing internal locus of control as women from this somewhat isolated rural community become more exposed to the beliefs and attitudes of "scientific" medicine through mass media, school, work, and contact with health care professionals. This trend toward increasing internality was manifested in their beliefs about the etiology of hypertension as well as in their health locus of control scores. The middle aged and younger adults ascribed considerably more causality vis a vis hypertension to variables over which the individual has control, i.e., dietary intake, worry, alcohol consumption, and life's pace rather than variables over which the individual has no control, i.e., old age, race, or variables over which the individual has relatively little control, i.e., magic, evil spirits, and God's will. On the other hand, the older women (60+ years) believed strongly that God's will, punishment for wrongdoing, and poisons in food-all variables over which the individual has relatively little control were important factors in the etiology of hypertension. Thus, the practitioner should approach the age groups differently.

For example, younger women (13-20 and 21-35 years can be approached directly with requests for alterations in behaviors using strategies delineated in the section on community education. However, with middle-aged and older women (36-59 and 60+ years), the practitioner can utilize their view of physicians as "instruments of God" to accomplish therapeutic goals that otherwise might seem contrary to the belief that ". . . it is up to God, whether or not they get well." Practitioners can employ their authority as an "instrument of God" to enjoin the patient to "help God" through the adoption of particular health promoting behaviors. In this manner, a hypertensive patient who appears an unlikely candidate for preventive health recommendations based on his or her apparently fatalistic belief system can be coaxed into taking prescribed medication or limiting their sodium intake.

Changing Patients' Behaviors through Utilization of Existing Practices

A second instance in which cultural information can be utilized to devise an effective treatment plan is in the area of behavior change. It is important to assess carefully the adaptive and maladaptive aspects of the patient's health beliefs and practices. Too often patients are asked to give up pleasureable activities without specific suggestions of substitutions. Medical anthropologists have long argued that patients should only be asked to change behaviors that are harmful. Neutral or beneficial practices should be left alone or utilized to accomplish other therapeutic goals.

For example, the use of prayer as a cure for hypertension might be considered harmful if used as the only healing strategy. However, if

considered a relaxation technique and thus a means of reducing stress, prayer can be used in conjunction with other treatment modalities to achieve blood pressure control in patients who are very religious and rely heavily on prayer for solace and inspiration. In fact, prayer contains the four necessary elements described by Hosten (1980) for eliciting the relaxation response: a repetitive word or sound, muscle relaxation, quiet environment, and removal of distracting thoughts. The practitioner can thus use his or her knowledge of the patient's belief system to therapeutic advantage.

Similarly, the practitioner can prescribe a realistic exercise or weight reduction program based on cultural variables. For example, the recommendation to walk down a country road for a prescribed distance will undoubtedly be easier for the rural based patient to accomplish than the advice to join a health club. Similarly, requesting dietary changes that comply with the patient's indigenous food habits and preferences will be more successful than suggestions to adopt a whole new food repertoire.

In summary, the creative practitioner can use cultural information to accomplish treatment goals. If therapeutic innovations are proposed in such a way that they fit into existing belief systems and health practices they will more likely be adopted. If these prescriptions are endorsed and reinforced by the patient's family they have an even greater chance for acceptance. The next section discusses the importance of enlisting significant family members to aid the treatment endeavor.

Enlisting the Aid of Significant Others in the Patient's Treatment Plan

It is therapeutically advantageous to include significant family members in the design of the patient's treatment plan, since the family is an important source of health information, social support, and medical referral. This research highlights the importance of older female relatives as ongoing sources of health care information and as a role model for succeeding generations. Thus, it may be helpful for the health care professional to establish a working relationship with these influential women so that they can aid in the therapeutic endeavor rather than act as deterrents to treatment goals. They should be included in health teaching, diet planning, medication scheduling, and exercise planning. Through this means these influential informal health agents can become therapeutic allies. Some examples will further elucidate this treatment strategy.

If the practitioner prescribes a particular medication and the patient's grandmother tells her that "those pills aren't any 'good,'" the patient is not likely to take the prescribed medicine. However, if the grandmother is involved in the health teaching and learns along with the patient that there may initially be some side effects or that the medication is to be taken even when the patient is asymptomatic, then the grandmother can reinforce the practitioner's advice.

Similarly, in the realm of diet planning and food preparation, it is often not the patient but a female family member who is responsible for cooking the meals. For example, education regarding the techniques for preparing tasty food using lemon juice, garlic, or some other herb or spice rather than salt should be addressed to the family cook as

well as the patient. Otherwise no amount of lecturing on salt restriction will yield the desired effects.

Family members are important for moral support and encouragement as well. It is difficult to be successful in altering existing patterns in a non-supportive atmosphere. Without enlisting significant family members in the process, the practitioner will be dooming his or her treatment plan to failure.

In summary, a number of recommendations have been made to ameliorate the "compliance problem" with hypertensive patients. It is argued that culturally appropriate treatment plans will have a much greater degree of compliance than those which disregard the importance of cultural variables. Restructuring the clinical encounter to include the patient and his or her support system as active participants in the treatment process is advised. Furthermore, recommendations were made for the design and implementation of community education efforts that are age specific and culturally relevant.

Since hypertension is a disease that is heavily influenced by life style behaviors, any attempts to alter these lifelong habits must be directed at both the individual patient and the community in which he/she resides. The importance of the extended family in the black community underscores the need to involve the total family and support network in health education efforts as well as treatment planning. Since the treatment of chronic illness is a life-long process, the importance of ongoing support from significant others is essential. The involved family can reinforce the practitioners health techniques, assist in behavior modification and encourage adherence to prescribed treatment.

Summary

The clinical applications of the research findings can be utilized in the treatment of other chronic illnesses, i.e., diabetes, sickle cell anemia, in much the same manner as described for hypertension. Furthermore, the generalizability of these strategies to other cultural groups has been discussed. Data from this research can be utilized by health practitioners to improve clinical care for a broad spectrum of patients in a variety of communities.

The importance of incorporating cultural information into both community education efforts and into the clinical encounter has been elucidated. A complex configuration of health information sources must be considered in designing any culturally relevant health care project.

Although the influence of older female relatives has been attenuated by the mass media in recent years, there is still evidence that the health beliefs, and practices inculcated by mothers, grandmothers, and aunts are forces to be reckoned with in accomplishing health education and medical practice goals. No matter how much value is placed on the physician's authority, his or her advice is carefully considered against these deeply ingrained health beliefs. Thus, the importance of these women as therapeutic allies and community change agents is clear. Afterall, women have always been healers--"My mama always said"

APPENDICES

APPENDIX A
REVIEW OF PATIENT EDUCATION PAMPHLETS

Blacks and High Blood Pressure, NIH See If You're Black, 1980.

Control Yourself: High Blood Pressure and How to Live with It,
New York State Health Department, 1977.

Health Enemy No. 1: High Blood Pressure, Merck, Sharp & Dohme,
West Point, Pennsylvania, 1982.

High Blood Pressure, American Heart Association, Dallas, Texas,
1980.

High Blood Pressure and You, Maryland High Blood Pressure Commission,
1981.

High Blood Pressure and What You Can Do About It, Benjamin Co., Inc.,
Elmsford, New York, 1982.

High Blood Pressure: Facts and Fiction, NIH, 1980.

High Blood Pressure Facts for You and Your Family, NIH, 1980.

High Blood Pressure Is Serious Business, Smith, Kline & French, 1981.

High Blood Pressure: It's Up to You to Keep It Down, USV Laboratories,
Inc., Manati, PR, 1980.

High Blood Pressure: Things You and Your Family Should Know, National
High Blood Pressure Education Program, National Heart, Lung and
Blood Institute, NIH, 1981.

High Blood Pressure: Your Doctor's Advice Could Save Your Life,
Merck, Sharp & Dohme, West Point, Pennsylvania, 1982.

How You Can Help Your Doctor Treat Your High Blood Pressure, American
Heart Association, Dallas, Texas, 1977.

Hypertension Is High Blood Pressure, Merck, Sharp & Dohme, West Point,
Pennsylvania, 1982.

If You're Black, Here Are Some Facts You Should Know about High Blood
Pressure, National High Blood Pressure Education Program,
National Heart, Lungs & Blood Institute, National Institutes of
Health, 1980.

Questions about Weight, Salt and High Blood Pressure, National High
Blood Pressure Education Program, National Heart, Lungs & Blood
Institute, National Institutes of Health, 1982.

To Beat Hypertension, You Have to Make a Few Adjustments, Ayerst
Laboratories, New York, 1980.

Understanding High Blood Pressure, Searle, San Juan, Puerto Rico,
1983.

Your Blood Pressure, Check It for Life, Montgomery County High Blood Pressure Control Program, Rockville, Maryland, 1979.

What Every Woman Should Know about High Blood Pressure, American Heart Association, 1981.

What Is High Blood Pressure, Jackson Memorial Hospital, Miami, Florida, 1982.

APPENDIX B
FOCUSED INTERVIEW GUIDE

FOCUSED INTERVIEW GUIDE

Card 1
 Code No.
 78-70 _____
 For data pro-
 cessing only

A. DEMOGRAPHICS

- | | |
|---|-------------|
| 1. Age in years _____ | 1-2 _____ |
| 2. How long have you lived in Macedonia - Grove? ____ yrs | 3-4 _____ |
| a. Ever lived away? 1. Yes 2. No | 5 _____ |
| b. Where? 1. Rural 2. Urban 3. Town | 6 _____ |
| c. How long? ____ yrs | 7-8 _____ |
| 3. When you were little were you raised by: | |
| 1. Both parents 2. Mother only 3. Father only | 9 _____ |
| 4. Grandmother 5. Aunt 6. Other relative (female) | |
| 7. Other relative (male) | |
| 8. Someone other than relative (female) _____ | |
| 9. Someone other than relative (male) _____ | |
| 4. When you were a teenager, who did you live with? | 10 _____ |
| 1. Both parents 2. Mother only 3. Father only | |
| 4. Grandmother 5. Aunt 6. Other relative | |
| 7. Someone other than relative (female) _____ | |
| 8. Someone other than relative (male) _____ | |
| 9. Boyfriend/husband | |
| 5. At what age did you leave home? _____ | 11 _____ |
| 1. never 2. 15-20 yrs. 3. 20-30 yrs. 4. over 30 | |
| 6. Do you now work outside the home? | |
| 1. Yes 2. No | 12 _____ |
| 1. Where? _____ 1. Rural | 13 _____ |
| 2. Urban | |
| 3. Town | |
| 2. For how long (yrs.)? _____ | 14-15 _____ |
| 7. Have you ever worked outside the home? | |
| 1. Yes 2. No | 16 _____ |
| 2. Where _____ 1. Rural | 17 _____ |
| 2. Urban | |
| 3. Town | |
| 3. For how long (yrs.)? _____ | 18-19 _____ |
| 8. Highest grade completed in school? | |
| 4, 5, 6, 7, 8, 9, 10, 11, 12 | |
| College: 13, 14, 15, 16 | |
| 17. Vocational training _____ | |
| 18. Other _____ | 20-21 _____ |
| 9. What kind of work do you do? _____ | |
| _____ | |

Code # _____

8. BELIEFS ABOUT HEALTH AND ILLNESS

I would like to read you some things that other people have said about sickness. Tell me if you totally agree, agree sometimes or disagree.

1. When people get sick, there is usually not much they can do about it.

1. Agree 2. Agree sometimes 3. Disagree

22 _____

2. If you lead a good life, you will rarely get sick.

1. Agree 2. Agree sometimes 3. Disagree

23 _____

3. Almost all diseases have a cure.

1. Agree 2. Agree sometimes 3. Disagree

24 _____

4. If the Lord wants to send you an illness, there is nothing you can do to stop it.

1. Agree 2. Agree sometimes 3. Disagree

25 _____

5. Some people get sick often while others always seem to stay healthy.

1. Agree 2. Agree sometimes 3. Disagree

26 _____

6. Most illnesses will be cured in a matter of time regardless of which treatments are used.

1. Agree 2. Agree sometimes 3. Disagree

27 _____

7. People who stay in good health are just lucky.

1. Agree 2. Agree sometimes 3. Disagree

28 _____

8. If you become ill, it is because you live under a lot of pressure.

1. Agree 2. Agree sometimes 3. Disagree

29 _____

9. In the future modern science will find a cure for all diseases.

1. Agree 2. Agree sometimes 3. Disagree

30 _____

10. Most people get sick because they worry too much.

1. Agree 2. Agree sometimes 3. Disagree

31 _____

11. When people eat right and take care of their bodies, they seldom get sick

1. Agree 2. Agree sometimes 3. Disagree

32 _____

12. When people get sick, it is up to God whether or not they get well.

1. Agree 2. Agree sometimes 3. Disagree

33 _____

13. There is no use worrying about illness. What will be will be.

1. Agree 2. Agree sometimes 3. Disagree

34 _____

14. When people are sick, it is usually a result of bad luck.

1. Agree 2. Agree sometimes 3. Disagree

35 _____

15. Most diseases can be cured by a good doctor with the right medicines.

1. Agree 2. Agree sometimes 3. Disagree

36 _____

						Code #
C. SOURCES OF GENERAL HEALTH INFORMATION						
1. How often do you read the <u>newspaper</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	37 _____
2. How often do you read articles about health in the <u>newspaper</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	38 _____
Topics/columns _____						
3. How often do you read <u>magazines</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	39 _____
4. How often do you read articles about health or medicine in <u>magazines</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	40 _____
5. How often do you listen to the <u>radio</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	41 _____
6. How often do you listen to programs about health on the <u>radio</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	42 _____
7. How often do you watch the <u>television</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	43 _____
8. How often do you hear about health on the <u>television</u> ?	1. Never	2. Daily	3. 1x/week	4. 1x/month	5. 6x/yr	44 _____
Type/programs: 0=no 1=yes						
1. Ads _____						45 _____
2. Exercise _____						46 _____
3. Nutrition _____						47 _____
4. Specials _____						48 _____
5. General _____						49 _____
6. Other _____						50 _____
9. Are there any <u>other</u> kinds of programs needed?						
1. Yes	2. No					

		Code #
10. Do you have any books or pamphlets on health at home that you turn to when you or someone you know is sick?		
O=No If Yes - State Numbers 1 - 7 (top 2)		
Specify	1. enclyclopedia 4. Bible 7>All	51
	2. health book 5. Herbal	52
	3. pamphlet from Dr. 6. other	
11. Is anyone close to you (like kin or someone you see regularly)		
a. Minister/preacher	1. Yes 2. No	53
b. Doctor	1. Yes 2. No	54
c. Dentist	1. Yes 2. No	55
d. Healer	1. Yes 2. No	56
e. Pharmacist/druggist	1. Yes 2. No	57
f. Worker in hospital or clinic	1. Yes 2. No	58
g. School teacher	1. Yes 2. No	59
h. Counselor	1. Yes 2. No	60
i. Other health care worker	1. Yes 2. No	61
12. Where would you say you got <u>most</u> of your information about sickness from?		
<u>Rank order:</u>		
1. Relative	1. Yes 2. No	62
2. Friend/neighbor	1. Yes 2. No	63
3. Doctor	1. Yes 2. No	64
4. Pharmacist/druggist	1. Yes 2. No	65
5. Bible	1. Yes 2. No	
6. TV, Radio, Movies	1. Yes 2. No	
7. Minister	1. Yes 2. No	
8. Books, newspaper, pamphlets	1. Yes 2. No	
9. Nurse	1. Yes 2. No	
10. School teacher	1. Yes 2. No	
11. Chiropractor	1. Yes 2. No	
12. Other	1. Yes 2. No	

	Code#
D. HYPERTENSION	
Now I would like to ask you some questions about "hypertension".	66 _____
1. DEFINITION	
a. What does "hypertension" mean to you? 0 = don't know	
1. very tense 3. high blood pressure	
2. hyperactive 4. other	
b. Is it the same as high blood pressure?	
1. Yes 2. No	67 _____
c. Another name for hypertension is high blood pressure. What is considered a high blood pressure?	
1. More than 140/90	68 _____
2. Less than 140/90	
3. 140/90	
4. Don't know	
d. Have you ever been told that you have high blood pressure?	
1. Yes 2. No	69 _____
e. By whom was it diagnosed?	
1. Doctor 2. Self	70 _____
3. Community screening done by nurse	
4. Other	
f. How long have you had high blood pressure (yrs)?	71-72 _____
g. What are you doing for it?	73 _____
1. Medication 4. Stop smoking	
2. Diet 5. Other	
3. Exercise	
h. Does anyone in your family have high blood pressure.	
1. Yes 2. No	74 _____
i. By whom was it diagnosed?	
1. Doctor 2. Self 3. Community screening by nurse.	
4. Other	
2. CAUSES	
a. What do you think causes high blood pressure? (Record all responses - code top 3)	
_____	75 _____
_____	76 _____
_____	77 _____
b. Some people think that these things cause high blood pressure. What do you think about high blood pressure being caused by:	

Card 2
Code# 78-80

a. Worry/aggravation/stress	1. Agree 2. Disagree 3.D.K.	1 _____
b. Old age	1. Agree 2. Disagree 3.D.K.	2 _____
c. Evil spirits	1. Agree 2. Disagree 3.D.K.	3 _____
d. Not getting enough rest	1. Agree 2. Disagree 3.D.K.	4 _____
e. God's will - fate	1. Agree 2. Disagree 3.D.K.	5 _____
f. Living a fast life	1. Agree 2. Disagree 3.D.K.	6 _____
g. Being nervous	1. Agree 2. Disagree 3.D.K.	7 _____
h. Roots, hexes, curses, spells, magic	1. Agree 2. Disagree 3.D.K.	8 _____
i. Fatty foods, cholesterol	1. Agree 2. Disagree 3.D.K.	9 _____
j. God's punishment for sinful behavior	1. Agree 2. Disagree 3.D.K.	10 _____
k. Smoking cigarettes	1. Agree 2. Disagree 3.D.K.	11 _____
l. Drinking alcohol	1. Agree 2. Disagree 3.D.K.	12 _____
m. Too much water in system	1. Agree 2. Disagree 3.D.K.	13 _____
n. Using too much salt on food	1. Agree 2. Disagree 3.D.K.	14 _____
Define "too much"		
o. Your genes-it runs in families	1. Agree 2. Disagree 3.D.K.	15 _____
p. Not enough exercise	1. Agree 2. Disagree 3.D.K.	16 _____
q. Being Black	1. Agree 2. Disagree 3.D.K.	17 _____
r. Being overweight	1. Agree 2. Disagree 3.D.K.	18 _____
s. Being afraid	1. Agree 2. Disagree 3.D.K.	19 _____
t. Working too hard	1. Agree 2. Disagree 3.D.K.	20 _____
u. Keeping feelings inside	1. Agree 2. Disagree 3.D.K.	21 _____
v. Poisons in food	1. Agree 2. Disagree 3.D.K.	22 _____
w. Other _____		23 _____

3. SYMPTOMS:

a. How does someone know they have high blood pressure? What are the signs? (Record all responses, code top 3 responses)	24 _____
	25 _____
	26 _____

Some people say these are signs. Do you agree or disagree?

a. Break into sweats	1. Agree 2. Disagree 3.D.K.	27 _____
b. Feel nervous, tense	1. Agree 2. Disagree 3.D.K.	28 _____
c. Have headaches	1. Agree 2. Disagree 3.D.K.	29 _____
d. Feel dizzy	1. Agree 2. Disagree 3.D.K.	30 _____

	Code #	
e. Having a pounding heart	1. Agree 2. Disagree 3.D.K.	31 _____
f. Having ringing in the ears	1. Agree 2. Disagree 3.D.K.	32 _____
g. Having a racing pulse	1. Agree 2. Disagree 3.D.K.	33 _____
h. Having nose bleeds	1. Agree 2. Disagree 3.D.K..	34 _____
i. Having emotional outbursts - bad temper	1. Agree 2. Disagree 3.D.K.	35 _____
j. Feeling faint	1. Agree 2. Disagree 3.D.K.	36 _____
k. Other _____	1. Agree 2. Disagree	37 _____
<hr/>		
b. If you don't feel sick, can you still have high blood pressure?		
1. Yes 2. No	38 _____	
4. EXPLANATION		
What happens to your body when you have high blood pressure? <hr/> <hr/> <hr/> <hr/>		
<hr/>		
Is a person with high blood pressure "sick"?		
1. Yes 2. No	39 _____	
5. CURE/CONTROL		
a. Can high blood pressure be cured?		
1. Yes 2. No 3. OK	40 _____	
b. What can help control high blood pressure? (Record all responses - code top 3)		
_____	41 _____	
_____	42 _____	
_____	43 _____	
c. Some people think these things can help high blood pressure. Do you agree or disagree?		
a. Using home remedies (specify)	1. Agree 2. Disagree 3.D.K.	44 _____
b. Praying	1. Agree 2. Disagree 3.D.K.	45 _____
c. Eating certain things/foods/ spices	1. Agree 2. Disagree 3.D.K.	46 _____
d. Staying away from certain things, i.e., salt, pork	1. Agree 2. Disagree 3.D.K.	47 _____
e. Reading the Bible	1. Agree 2. Disagree 3.D.K.	48 _____
f. Taking medicine you can buy at the store (OTC)	1. Agree 2. Disagree 3.D.K.	49 _____
g. Using herbs/roots/teas	1. Agree 2. Disagree 3.D.K.	50 _____
h. Getting exercise	1. Agree 2. Disagree 3.D.K.	51 _____
i. Taking medicines the doctor prescribes	1. Agree 2. Disagree 3.D.K.	52 _____
j. Laying on of hands	1. Agree 2. Disagree 3.D.K.	53 _____

	Code #	
k. Losing weight	1. Agree 2. Disagree 3.D.K.	54 _____
l. Relaxing/resting	1. Agree 2. Disagree 3.D.K.	55 _____
m. Using oils, incense, or special lotions, powders	1. Agree 2. Disagree 3.D.K.	56 _____
n. Wearing certain objects or clothes	1. Agree 2. Disagree 3.D.K.	57 _____
o. Living the right kind of life (specify) _____	1. Agree 2. Disagree 3.D.K.	58 _____
p. Other _____	1. Agree 2. Disagree	59 _____
d. Are you now doing anything to help high pressure? 1. Yes 2. No Specify _____		60 _____
6. REFERRAL		
a. If you thought somebody you knew might have high blood pressure, who would you tell them to see about it?		
1. Their minister 2. Another friend 3. Their kin 4. A rootworker 5. A doctor 6. A faith healer/spiritualist 7. A granny 8. A pharmacist/druggist 9. A nurse 10. A chiropractor (Code as 0) 11. Other _____		61 _____
b. How often should a person with high blood pressure see somebody about it? 1. Weekly 2. Monthly 3. Every 3 months 4. 2x/year 5. Yearly 6. Whatever Dr. says 7. Other		62 _____
7. CONSEQUENCES		
a. What can happen if a person has high blood pressure and they do not take care of it? Do you think they would get: 1. A stroke 2. Yes 3. No 3. D.K. 2. Nothing 1. Yes 2. No 3. D.K. 3. A heart attack 1. Yes 2. No 3. D.K. 4. Other heart problems 1. Yes 2. No 3. D.K.		63 _____ 64 _____ 65 _____ 66 _____

	Code #	
5. Kidney problems	1. Yes 2. No 3. D.K.	67 _____
6. Feeling run down	1. Yes 2. No 3. D.K.	68 _____
7. Lose their nature	1. Yes 2. No 3. D.K.	69 _____
8. Die early	1. Yes 2. No 3. D.K.	70 _____
9. Hardening of arteries	1. Yes 2. No 3. D.K.	71 _____
10. Becoming paralyzed	1. Yes 2. No 3. D.K.	72 _____
11. Other _____	1. Yes 2. No	73 _____
<hr/>		
b. Can these things happen even if a person takes care of their high blood pressure?		
1. Yes 2. No 3. D.K.	74	_____
8. PREVENTION		
a. Can we keep people from getting high blood pressure?		
1. Yes 2. No 3. D.K.	74	_____
b. Which of these things will help?		
a. Getting exercise	1. Yes 2. No 3. D.K.	Card 3 1 _____
b. Staying calm	1. Yes 2. No 3. D.K.	2 _____
c. Living a normal life	1. Yes 2. No 3. D.K.	3 _____
d. Limiting salt	1. Yes 2. No 3. D.K.	4 _____
e. Eating low fat, low cholesterol foods	1. Yes 2. No 3. D.K.	5 _____
f. Losing weight - if overweight	1. Yes 2. No 3. D.K.	6 _____
g. Drinking a couple of beers each day	1. Yes 2. No 3. D.K.	7 _____
h. Not smoking cigarettes	1. Yes 2. No 3. D.K.	8 _____
i. Staying busy	1. Yes 2. No 3. D.K.	9 _____
j. Going to church regularly	1. Yes 2. No 3. D.K.	10 _____
k. Getting enough rest	1. Yes 2. No 3. D.K.	11 _____
l. Eating certain things (specify)	1. Yes 2. No 3. D.K.	12 _____
<hr/>		
m. Reducing tension	1. Yes 2. No 3. D.K.	13 _____
n. Praying	1. Yes 2. No 3. D.K.	14 _____
o. Other _____	1. Yes 2. No 3. D.K.	15 _____
<hr/>		
c. Are you now doing anything to prevent high blood pressure?		
1. Yes 2. No 3. Already have high blood pressure	16	_____
Specify all - code most significant _____	17	_____
<hr/>		

	Code #
9. SOURCES OF INFORMATION	
a. How can people find out about high blood pressure?	
1. More TV and radio programs on this problem	1. Yes 2. No 18 _____
2. Screening programs in the community	1. Yes 2. No 19 _____
3. More information from doctors/ nurses	1. Yes 2. No 20 _____
4. Church sponsored health education programs	1. Yes 2. No 21 _____
5. Training people in the community to teach others about it	1. Yes 2. No 22 _____
6. Teach about it in schools	1. Yes 2. No 23 _____
7. Other _____	1. Yes 2. No 24 _____
<hr/>	
b. Do you need more information about high blood pressure?	
1. Yes 2. No	25 _____
<hr/>	

for coding purposes only

10. RELATIONSHIP & GENERATION	26 leave blank
a. Age cohort	27 _____
1 = 13-20 yrs 2 = 21-35 yrs 3 = 36-59 yrs 4 = 60+ yrs	
b. Family number (01-23)	28-29 _____
c. Relationship	30 _____
1 = mother 2 = daughter 3 = granddaughter	
if more than 1 in family, order by age	
	31 _____

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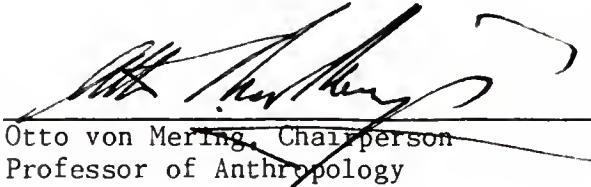
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BIOGRAPHICAL SKETCH

Elizabeth Randall-David was born in Baltimore, Maryland, on January 20, 1944. In June of 1961, she graduated from Roland Park County School in Baltimore. She received a Bachelor of Science degree from Duke University in 1965, a master's degree in psychology from the New School for Social Research in 1968, and a Bachelor of Science in Nursing degree from the University of Florida in 1975. In the past 10 years she has worked as a clinician, educator, and/or researcher in the areas of women's health, community medicine, and organizational development. She is particularly interested in the clinical application of social science concepts. She lives in Gainesville, Florida, with her two sons, Benjamin and Jonathan.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.



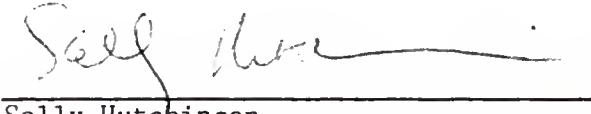
Otto von Mering, Chairperson
Professor of Anthropology

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Molly Dougherty
Professor of Nursing

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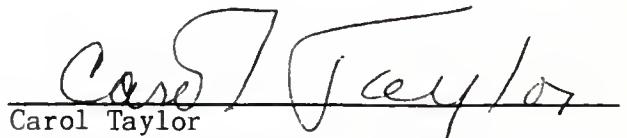
Sally Hutchinson
Assistant Professor of Nursing

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Charles Mahan
Professor of Obstetrics and Gynecology

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Carol Taylor
Assistant Professor of Nursing

This dissertation was submitted to the Graduate Faculty of the Department of Anthropology in the College of Liberal Arts and Sciences and to the Graduate School, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

May, 1985

Dean for Graduate Studies and Research

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